# HEALTH REFORM AND

# THE IMPACT ON MÄORI

# 1983 –1997

A thesis

submitted in fulfilment

of the requirements for the Degree

of

Doctor of Philosophy

at the

University of Waikato

by

LISA ARLEEN FERGUSON

---

University of Waikato

2002

# ABSTRACT

This study investigates the New Zealand health sector reforms from 1983 to 1997 and examines whether the reform process has been consistent with the principles of the Treaty of Waitangi. It evaluates the impact of the reforms on Mäori from that perspective.

The study introduces the health sector reforms generally and then their specific effects on Mäori. It draws on two research exercises undertaken by the author, being research for the Wai 692 Napier Hospital and Health Services claim to the Waitangi Tribunal and on improving Mäori Health outcomes for the National Health Committee. The methodologies used are those from the discipline of history.

The study outlines the argument for Crown responsibilities under the Treaty and draws out the distinctions between Article 2 and Article 3 of the Treaty. It provides a historical background to the place of the Treaty in the health sector, and forms the basis for a Treaty based analysis of the health reforms and their impact.

The New Zealand health sector has undergone massive government initiated structural change throughout the period under study. During this time the neo-liberal reforms have had a key role in reshaping health service structures. The process of change, the international influences on the changes, and the resulting entities are described. An example from Tainui Iwi of the effect of structural health reform illustrates the changes in Mäori health service provision by Mäori.

Since 1983 successive governments have produced copious Mäori health policy. The key policy documents, and their recommendations, are identified, as is the degree to which they were implemented. The cyclical nature of such policy making suggests that it is not always followed by policy implementation. While Mäori are identified as a health gain priority, the evidence reviewed shows that the responsibility to implement and monitor the policy is diffuse and ineffective.

The Wai 692 claim provides a detailed look at the impact of the 1990s health reform for Mäori. The claim was precipitated by the threatened closure of Napier Hospital, but was broadened to include a wide-ranging look at the impact of health reform on Mäori. As a case study it provides a specific example of one Iwi's experience of the reality of policy implementation at that time versus policy making.

Crown evaluation of the effectiveness of its own policies, and the extent to which its own agencies breach those policies is explored. The lack of control and accountability measures, plus the inability of the Crown to monitor (let alone sanction) success or failure, is highlighted. A contrast is drawn between the health and local government sectors, using the operation of the Resource Management Act (1991).

The latest health sector reforms consequent on the 1999 Labour/Alliance coalition government are briefly considered, together with an overview of the Crown's effectiveness in delivering improved Mäori health outcomes. The study suggests

that the use of the Treaty as a cornerstone for Māori health policy formation and delivery may lead to more effective engagement between the Crown and Māori in addressing Māori health issues. The study concludes by asking the question, has the health sector reform process of the 1980s and 1990s itself been a Treaty breach?

A brief postscript considers the further reform of the health sector beyond the period of study.

# ACKNOWLEDEGMENTS

The process of acknowledging or thanking those that have assisted me seems somewhat inadequate in many cases. A thesis takes the researcher on a journey that cannot be predicted when one sets out and my journey has been long and eventful.

Dr John F Smith is one of those people for whom acknowledgment of his commitment to my PhD research feels inadequate. When we set out on this journey John F agreed to be Chief Supervisor with Dr Richard Benton as the second. Four years on much has changed.

I was initially drawn to Waikato University for the multi-disciplinary graduate programme, Health Development and Policy, within the School of Social Sciences. There was much to attract me from Auckland University: the opportunity to research the recent reform period with the support of the Director, John F Smith was an exciting opportunity. In the four years since my enrolment at the University of Waikato the Health Development and Policy programme has been disbanded and for some time John F and myself were orphans. Despite the career changes and shifting geographic locations John F continued to maintain the supervision relationship providing enormous support and encouragement to me.

Professor Neil Erikson rescued me from my orphanhood and provided me with a home within the University's International Global Change Institute (IGCI). He later stepped into the breach and agreed to be a second supervisor. Professor Erikson, staff and students of IGCI have been most hospitable and welcoming. He

has contributed another perspective from his own discipline and research in his gently challenging way.

Dr Richard Benton played an important role in the early phases providing the opportunity for long discussions and debate that contributed to the development of the argument. He challenged my assumptions and assisted in formulating a broader argument. It was unfortunate that he could not continue as a supervisor but his contribution was much valued.

The Health Research Council awarded me a three-year Doctoral Scholarship. This was significant as it made the difference between being able to be totally committed to the research and wherever it took me and not having to be distracted by the realities of having to earn a living. For this I am most grateful.

To the claimants of Wai 692 without you there would be no story. Thank you for the opportunity to work alongside you and the people of Ngati Kahungunu. Without the approach of Peter Callinicos in the first place to ask would I consider working on the claim we would not have been brought together. Also thanks to the Waitangi Tribunal and particularly Richard Moorsom who provided me with the opportunity to work on the first health claim to the Tribunal. Richard Moorsom who patiently worked alongside and guided me in the complexities involved in challenging the Crown. Thank you so much.

There are many people who have patiently allowed me the opportunity to discuss and explore the argument that I was beginning to construct and refine. To them I

thank you for the time in your day to listen and respond, the staff of the Eru Pomare Centre, Mere Balzer, Keri Parata, Julia Carr…

The journey has been long and eventful. My youngest child has not known life without the PhD. My children have been most tolerant of their mother who has wandered the country in the pursuit of research. To my parents that have offered a haven in their home providing a place to write. Their many small kindnesses from cups of tea, meals and childcare have made the difference at times between making a deadline or not. Grace Brindle was the good fairy of childcare that allowed me to work without the internal conflict around neglect and abandonment of my children. She also makes a damn fine pot of coffee. I am most grateful.

To the people of Waikeri Marae particularly the Moke whanau, thank you for your unfailing support. I have valued the kaumatua guidance and supervision to keep me on track.

To my tane Henry thank you is inadequate. This has been a shared journey that at times has felt both a huge burden and gift. I cannot list all that you have done. What I most personally want to acknowledge is your belief in me. At times it exceeds my own.

# CONTENTS

Tables

# CHAPTER 1 - INTRODUCTION

**Mr Powell.** Now, could I ask you to go through paragraph 4 of your evidence. And you note the primary objective, in the green and white paper *(the 1991 health reform design[1])*, the primary objective of this reform process must be to secure for every one access to an acceptable level of health care. I'm just - that's not really a new objective for the health services, was it?

**Mr Clarke.** No, indeed. Words similar have been stated in 1948, 1956 and 1973.

**Mr Powell.** So, the primary objectives of the reforms were actually no different than anything that's gone on before?

**Mr Clarke.** The primary objectives of any health system are to provide access to services that are safe, that are affordable, and are appropriate to the needs of individuals, within an acknowledged fixed budget.

In that sense, no, the objectives are no different in 1999 than they were in the early 70s. However, the pressures in terms of technology, in terms of the advancement of information, have perhaps, if anything, reinforced the importance of those objectives (Clarke, 1999, p19)

Chris Clarke, Team Leader, Targeted Assistance Group, Crown Company Monitoring and Advisory Unit (CCMAU, a unit of Treasury) in reply to cross-examination by Grant Powell, counsel for the claimants, Wai 692, the Napier Hospital Services Claim (the first health claim to the Waitangi Tribunal.)

## Health Reform

While the New Zealand health sector reforms of the 1990s were presented as being unique, new, and innovative, health care reform has never been out of fashion. The tension between "out with the old, in with the new," and "there is nothing new under the sun" has been almost axiomatic in these health reforms (Kelsey, 1990, p30). Each reform seems to be sold to the public as a revolutionary opportunity to finally remedy the health deficits of the existing structure.

---

[1] Explanatory note, author's emphasis

However, as the above quote shows, in fact, while the structures are new, the objectives are much the same as they have always been.

Health reform in New Zealand has sat in the space between two ways of viewing the world. During the 1930's the first Labour government designed and built a welfare state based on a model of universal entitlement (Social Security Act, 1938) (Richards, 1994). Throughout the period until the 1984 Labour government, the welfare model was the basis of a broad consensus, not only between the two governing political parties, but also across society as a whole. Health reform went on, but it was basically minor changes to the structures, with little threat to the underlying worldview or consensus.

In 1983 the model started to change, with the introduction of Area Health Board legislation, where communities could opt for a wider health focus than the traditional hospital-oriented health governance and management structures (Beaglehole and Davis, 1992). The election of the 1984 Labour government accelerated the change, where the option became mandatory, and the first cracks in universality appeared, such as the introduction of user part charges for pharmaceuticals.

The Area Health Board model was still widely accepted however, as it maintained most aspects of the social consensus, particularly the substantial part of universality. By the late 1980s Area Health Boards had been implemented throughout New Zealand, effectively only the second major New Zealand health sector reform in over 50 years. With the advent of the 1990 public sector reforms

however, the move to a state provided "safety net" of targeted assistance for those most in need, a move away from universal entitlement, became very evident in most aspects of the welfare state. Health was no exception, and part charges, and the rationing of so-called elective health care became a major feature of the health reforms of that time.

The degree and frequency of recent structural change in the New Zealand health sector can easily lead to confusion on the part of an observer as to the various entities, the roles that they have played, and the chronological period in which they have operated. Some degree of orientation to help overcome that confusion will be provided in Table 7: Health Entities 1983 -1997 on page 245.

## Health as Society's Identity

New Zealand has seen itself as an egalitarian society since the 1930's, if not before. Health services were a key part of the welfare provisions that grew out of the 1930's (Social Security Act 1938) and have thus become integrally bound with New Zealand's identity. This view is not a feature of New Zealand in isolation, but a common one in many of the western democracies, particularly Scandinavian and British Commonwealth countries. As Aneurin Bevan the founder of the National Health Service has described it:

> Society becomes more wholesome, more serene and spiritually healthier, if it knows that its citizens have at the back of their consciousness the knowledge that not only themselves, but all their fellows have access to the best health care that society can provide (Hall & Viney, in Bloom, 2000, p49)

Health and health services have become one of the key elements in how these kinds of societies defines themselves. When a society is going through a radical

redefinition of itself, it is not surprising that the health services are reformed to match the new identity.

Like many aspects of New Zealand society, the health system has been involved in a "strife of ideologies" (Hall & Viney, in Bloom, 2000, p49). On the one hand, a view widely held by most New Zealanders going into the 1990s reforms under study, was that health is a social good, a public good. And on the other hand, a view of health as a commodity within the market place, a private good to be largely provided for at a private cost was emerging.

> New Zealand's present system of providing primary health care in particular, but also secondary care, is discriminatory, inconsistent, and heavily biased in favour of certain forms of treatment. The people who most need care are often those with least access to it. At present the well off pay little more for basic medical care than those who can least afford it. Because the government subsidises everyone's medical expenses those who really cannot afford medical care are not receiving enough help (Douglas, 1993, p63)

The structure of the New Zealand health system from 1938 and its subsequent changes have reflected that ideological struggle. The universality of welfare, including health provision, established by the Social Security Act 1938 in which the State paid for (theoretically) all citizens to have equal access to the health care they needed, prevailed until the early1980s. Since then, this view was increasingly replaced by a more market driven philosophy, where it is considered that the consumer should pay all or part of the cost of their health care, dependent on their ability to pay, rather than their health need. Thus, the state pays should become the user pays.

The health sector has always been a mass of competing purposes and interests. Easton writes (1997, p153-155) of the state of the public health sector in 1990 as a 'battlefield' on which the newly elected National Government launched a reform 'blitzkrieg'. On the right of the 'battlefield, the New Zealand Medical Association and its allies (including the private health insurance and pharmaceutical sectors). On the left a mishmash of the public and smaller interest groups such as the Intellectually Handicapped Children's Society (IHC). And in the centre the Area Health Boards, all with different interests, and different patches to protect including tensions between maintaining medical autonomy and income, between cost control and prevention/promotion versus treatment, between child health and health of the elderly.

Critics of health reform as a process itself have pointed to its lack of theoretical and philosophical underpinnings (Seedhouse 1995). That lack provides an ideal battleground for competing interests to play out. When this occurs within the context of two distinct ideological stances, the prospects for a rational reform process are bleak.

> Health reform turns out either to be reform dominated by the single purpose of reducing fiscal cost, or reform inspired only by theories of purpose generated by the supposedly ailing system itself (Seedhouse 1995, p11).

When health reform has been driven by competition of many interest groups within and between those two ideological viewpoints, it is not surprising perhaps, that for Mäori, who fit neatly within neither ideological framework, health reform has not been an unqualified success. Indeed, from the point of some Mäori commentators, things have seldom been worse.

> We are living in the only decade of the twentieth century in which the health of Mäori is, by critical measures, not improving, and indeed is likely to be worsening. Premature death is the ultimate cost for being on the losing side of social change. The price to Mäori of New Zealand citizenship has never been higher in more than a hundred years. If Mäori health status is a proxy measure of good government as guaranteed in Article 1 of the Treaty of Waitangi, recent governments and their social and economic policies have been found lacking (Reid, 1999, p93).

## Research Aims and Questions

> ... any consideration of the Treaty of Waitangi, which was rarely mentioned in discussion of health issues before 1940. Several speakers at a meeting of North Auckland Mäori councils held at Kaikohe in 1938 referred to the fact that the 1900 Mäori Councils Act had been implemented at the request of Mäori to carry out in some measure the spirit of the Treaty of Waitangi (Dow, 1999, p14)

The Crown may have at times forgotten to mention or discuss the role of the Treaty of Waitangi in health. Mäori have always held the Treaty as central in their endeavours to have the Crown honour its undertakings made to them in 1840. Mäori health status cannot be considered in isolation from the Treaty.

I have chosen the period 1983 to 1997 as the period of study for several reasons; it marks the time of major social change in New Zealand's recent history, the emergence of the "New Right" as a political force and ideology and it provides a period in which both left and right wing governments have undertaken major structural changes in the health sector. Perhaps most of all, though, it encompasses the entire period in which the structural identity of the New Zealand health system was transformed, and the previous consensus was replaced by health becoming a defining difference in political positions. The Treaty of Waitangi has played a shifting role in both the political and health sector transformations.

The research is underpinned by a number of questions. If health care is a key element of how our society sees itself, and health sector processes breach the Treaty, what does that say about the delivery of health service in contemporary society? Has reform been an inclusive Treaty partnership experience for Mäori? Can Mäori act as full and equal partners within the health sector, as Article 3 of the Treaty suggests they should be able to?

The overall question underpins the research: Is the health reform process of the 1980s and 1990s in itself a breach of the Treaty of Waitangi obligations the Crown has to Mäori?

## A Monocultural versus a Pluralist society

Mäori have a unique position in New Zealand, that of tangata whenua, the people of the land. The Treaty of Waitangi (Kawharu, 1989) recognises that pre-eminence of Mäori in New Zealand, and by doing so recognises that there are (at least) two distinct groups in New Zealand society, tangata whenua, those who were here first, and tauiwi, those who came later.

Much of New Zealand history since the signing of the Treaty in 1840, is about the tension between the dominant cultural view, perhaps first expressed by William Hobson's statement at the signing that we are one people (Walker, 1990), and that of Mäori, seeking to exercise their rights under the Treaty. Because of the Treaty, Mäori view their rights as different to those of other New Zealanders. Thus arises the tension with the dominant view.

A central postulate investigated in this thesis is that both the conflicting ideologies driving health reform over the period of this study have served Mäori health status poorly. The universal health system, based on the egalitarian society, can be described as a one size fits all approach. It has been mono-cultural, and advantaged the dominant culture while servicing Mäori inadequately. It is further postulated in this thesis that this homogenising view has ignored the special needs and desires of Mäori.

However, that is not to say that Mäori health status could simplistically be raised to that of other New Zealanders merely by the Crown giving due emphasis to the Treaty of Waitangi in establishing and carrying out health policy. Both the Crown and Mäori agree on the need to remedy Mäori health status. This research seeks to investigate the proposition that the Crown's attempts during the period of study to remedy Mäori health status in a largely unilateral way, rather than using frameworks for partnership consistent with the Treaty of Waitangi, have neither solved the problem of Mäori health status, nor met Mäori aspirations in respect of participation in health sector decision making.

The research examines the degree to which Mäori health interests have been caught between the two most recent competing ideologies, and the impact the reform process of the 1980s and 1990s has had on Mäori health aspirations and status. It investigates how successfully an ideologically driven state health policy, irrespective of the basis of the ideology, engaged Mäori as partners in the health sector, or as determinants of their own health status.

It will be argued that the health market ideology infused into the system since the early 1990s has not fared much better and that targeted assistance has tended to break down the social compact identified in the Bevan quote on page 3.

Mäori have been treated as a competing interest in the health market and Mäori have treated health as another Iwi development vehicle. Mäori themselves have contributed to this effect. Health has replaced land as a lead vehicle in Iwi development in many Iwi (Durie, 1994).

> **MR POWELL (Counsel for the Claimants, Wai 692):** Now, if new needs come up for those - those particular three providers encounter that they want to expand their services, because they see a need to do so, they have to go back and renegotiate their contract with the Health Funding Authority, don't they, otherwise they'll get into trouble?
>
> **MS EARP (Deputy Director General, Mäori Health, MOH):** That's - part of the process at the moment is that, yes, they would renegotiate with the HFA.
>
> **MR POWELL:** And at that point, when they go back, they really - they could well find themselves in competition with the HHS, with Healthcare Hawke's Bay, which has set itself up to be the greatest provider of Mäori Health Services?
>
> **MS EARP:** Or other independent primary care providers as well. I mean, part of the primary care is - includes GP services, so GP's are a very significant component, or a significant part of primary care providers.
>
> **MR POWELL:** But, in terms of the HHS, it's got an advantage over Mäori providers in the sense that, the HFA has to look at the additional cost, fiscal risk or fiscal cost, of contracting services to somebody other than an HHS, doesn't it? (Earp, 1999, p155, 156)

## The State and the Other

As a disillusioned psychiatric nurse tired of ethical dilemmas it was never my intention to retrain and work within another sphere of health and medicine. My interest in the social history of health and medicine in New Zealand was not inspired by the good deeds of doctors and nurses in the pioneering history of New

Zealand. It was the realisation that the politics of health in the contemporary context was part of a much more complex and historic dynamic.

Working in psychiatry for 17 years my working life was dominated by defining deviance and judging behaviour by the definition of society's norms. These norms were validated and legitimised by the medical profession. It was in the discipline of history that it became evident to me that "science" and the application of it was critical to the State to fulfil any chosen agenda. While health and medicine have generally been perceived as neutral or objective this is not the experience of colonised or oppressed peoples. Medicine has been active in establishing and maintaining a relationship of power and authority between rulers and ruled (Nicolson, 1988). My interest in the role of health professionals (including myself) as agents of the state developed further.

University study in the early 1990s led me to focus my interest on history, particularly New Zealand social history. During the course of my M. A. study, I found myself once again coming back to an interest in health and medicine, but now from an historical perspective. My M.A. research began to formalise my interest in the health sectoral experience of indigenous people, particularly Mäori. My M.A. thesis used oral history to help tell the story of the establishment and development of health initiatives in the Tainui Iwi.

The book that expanded the range of views I had on science and its supposed objectivity was Said's 'Orientalism' (1978). It has been one of the most influential

in presenting a framework that enabled me to tell the story of the other from the perspective of the other. This thesis is part of that story telling process.

Said challenges the Western intellectual tradition and worldview. He demonstrates that there could be more than one world view and validates the views of the defined "other". For indigenous, colonised and dispossessed peoples the reality of the colonised experience is that the only perspective or worldview of any validity is that of the western intellectual tradition. Indigenous people value the opportunity to tell their own stories, rather than be objects of study.

Earlier historical accounts of 18th and 19th century European explorers made reference to the number of scientists and medical practitioners who accompanied them on their expeditions. Said describes the invasion of Egypt by Napoleon in 1798 as not driven entirely by conquest and acquisition, but a fascination with a previously inaccessible society. Napoleon had a desire to have that society completely open and available to European scrutiny.

> From being a land of obscurity and a part of the Orient hitherto known at second hand through the exploits of earlier travellers, scholars, and conquerors, Egypt was to become a department of French learning (Said, 1978, p83)

In 1798 the Institut d'Egypte was founded with the intention that it would build a living archive for the expedition and conquest of Egypt. The Institut comprised of teams of chemists, historians, biologists, archaeologists, surgeons, and antiquarians and described by Said as the learned division of the army.

> Its job was no less aggressive: to put Egypt into modern French... Almost from the first moments of occupation Napoleon saw to it that the Institut began its meetings, its experiments – its fact-finding mission, as we would call it. Most important, everything said, seen, and studied was to

> be recorded, and indeed was recorded in that great collective appropriation of one country by another, the *Description de l'Egypte*, published in twenty-three enormous volumes between 1809 and 1828 (Said, 1978, p.84)

The secretary of the Institut Jean-Baptiste-Joseph Fourier described in the preface of volume one of *Description de L'Egypte,* the benefits of colonisation and exposure to a more civilised society and the means of achieving that. Fourier gives credit to the contribution of science and the arts to achieving the original vision.

> Napoleon appreciated the influence that this event would have on the relations between Europe, the Orient, and Africa, on Mediterranean shipping, and on Asia's destiny... Napoleon wanted to offer a useful example to the Orient, and finally also to make the inhabitants' lives more pleasant, as well as to procure for them all the advantages of a perfected civilisation.
> None of this would be possible without a continuous application to the project of the arts and sciences (Said, 1978, p. 83)

Said's writing struck a chord with me. I could see parallels to the exploration and colonisation of the Pacific. There was a sense of connectedness and common experience with other colonised indigenous peoples framed within an academic debate that redefined the West as the 'other'. Orientalism described the application of the western tradition to the Near East and the defining of those societies was replicated in New Zealand. On Cook's voyage of rediscovery in the 18th century he travelled with four medically qualified men, a botanist, an artist, a natural historian and an astronomer. Gluckman states in 'Medical History of New Zealand Prior to 1860' (1976) that "this company, together with Cook and his officers obviously embodied the great potential for great observations and conclusions. Endeavour on this three year voyage can be looked upon as a

floating laboratory with high intellectual climate". Observations of Mäori were documented and judgements passed.

> During one of Cook's visits it was noted that ' every house, or every little cluster of three or four houses, was furnished with a privy, so that the ground was everywhere clean. The offals of their foods, and other litter, were also piled up in regular dunghills'. Like other observers, Banks thought the Mäori were not very 'cleanly in their persons' (Lange, 1972).

The observations and judgements of Mäori were filtered and shaped by the prevailing ideology of imperialism which maintained the strong belief of the biological and cultural inferiority of non-European peoples. This belief was reinforced by the medical and religious beliefs of the time.

> .... Cook concluded that Mäori in 1769 were a healthy race: 'a further proof that human nature is here untainted by disease is the great number of old men that we saw, many of whom by the loss of their hair and teeth appeared to be very ancient, yet none of them were decrepit, and though not equal to the young in muscular strength were not a bit behind them in cheerfulness and vivacity....' '.... In all our visits to their towns where young and old, men and women, crowded about us, we never saw a single person who appeared to have any bodily complaint, nor did we perceive the slightest eruption upon the skin or any marks that any eruption had left behind' (Durie, 1994, p24-25)

In the reading of those accounts it becomes evident that the role of scientists and doctors was to define the "other" and make sense of the alien world. The voyages of exploration and discovery treated the contact with new societies as scientific projects. Scientists defined, reified, explained and rationalised the behaviours, practices and structures of these new societies.

Medical opinion at the time used 'objective' science and their legitimate close contact with the indigenous population to give authority to their opinion. The scientific opinions on Mäori health status were not static and shifted depending on how Mäori were viewed by the colonisers at the time. At the time of first contact

between Mäori and Pakeha Mäori health status was observed by Cook to be impressive. When the relationship between Mäori and Pakeha deteriorates in the second half of the nineteenth century the scientific opinion on Mäori reflects it.

Dr Alfred Newman' an English trained doctor who returned to New Zealand in 1875 to practise medicine briefly' provides an example of this. Newman is described as having played a significant role in colonial science due partly to his becoming president of the Wellington Philosophical Society in 1879 and 1885 and publishing numerous papers in the Institute's journal between 1876 and 1909. Early papers utilised his medical training to analyse Mäori and Pakeha demography. In 1882 he published 'A study of the causes leading to the extinction of the Mäori', in which he depicted the race as diseased, depraved and brutal, dying out before the arrival of the Europeans' (J. Stenhouse, in 'The Dictionary of New Zealand Biography', Volume 3, 1996, p 358-359)

Dr Newman presented his study to the Wellington Philosophical Society in 1882 and argued that Mäori were congenitally incapable of the forms of behaviour required to maintain health.

> The whole evidence of modern medicine shows, beyond a shadow of a doubt, that the two chief causes of phthisis amongst all nations is the intermarriage of phthisical people and dwelling on low, damp, ill-drained soils: yet these as the very things which the Mäori seem to prefer doing. Amongst ourselves the awful ravages of phthisis may be either entirely checked or greatly abated, by care, by medicine, by nursing, and by change of climate, of all of these the Mäori knows nothing... he never takes care of himself (Nicolson, 1988, p89)

In the examples provided I have attempted to demonstrate the power of health and medicine to shape, influence and ultimately determine how the colonised will be understood. In both the Said and New Zealand examples doctors and scientists

have played an important role in the documenting of their observations and opinions, or passing judgement, which are then committed to the academic archives for succeeding generations. Due to how their professions are perceived, their observations shaped by their own personal views and cultural beliefs are treated as the definitive word on the societies that they pass judgement on.

Given the credibility given to the so-called objectivity of science then it is not such a huge leap that it must influence how governments have developed and implemented health policy in the last two centuries. Health policy could be viewed as an indicator of prevailing attitudes as it indicates how a society treats its members and the value placed on them.

So what is the relevance of all this to developing a doctoral research topic? Having worked in the New Zealand health sector since 1979 I have lived through the major changes of the 1980s and 1990s and the shift in ideology. I have observed the realities as an employee buffeted in the succeeding, repetitive and cyclical changes. It is a case of having lived the history of some of the most significant changes to and within New Zealand society.

The timing of these major changes in the 1980s and 1990s coincides with the growing awareness within Mäori communities of the significance of health and healthcare provision, and the realities of the monocultural system. From the early 1980s health became highly politicised and rivalled land as the issue that became the focus for Mäori hopes and aspirations.

In 1984 the Hui Whakaoranga, the Mäori Health Planning Workshop, at the Hoani Waititi Marae was a major national hui for Mäori health and provided a focus for a collective direction (Durie, 1994, p53, p211) It was at this hui that an important link was made between health and political advancement, that health was constituted as an integral component of Mäori development. Mäori were intent on defining health for themselves, and linking advances in health with advances in other areas such as Mäori language development, marae development, tribal development and Mäori political aspirations for greater autonomy.

Political developments of the 1980s and 1990s indicate that the issues raised at Hui Whakaoranga were significant for Mäori and health provided the political vehicle. Tainui led the country in the development of health initiatives that challenged the way in which the State had traditionally provided health services and information to Mäori. My MA thesis *Marae based health initiatives within the Tainui Iwi 1983 to 1995* examined the basis for the Tainui model and where they had taken community development. The health reforms of the early 1990s provided opportunities for Tainui to develop a wider range of health services and increase the number of initiatives. The changes in government policy allowed Mäori into the health sector market as players and access to the health dollar which had previously been denied. This was a major contributing factor to the escalating number of Mäori health initiatives of that time.

This development raised questions as to whether this was what would be in the interests of Mäori, to address the appalling health status issues or suited an agenda

of the governments. The reforms led to development opportunities for Mäori in the health arena. It is, however, arguable that the development and shape of the initiatives which have resulted is at least as much a matter of the economic ideologies driving the health reforms as it is an example of tino rangatiratanga, or Mäori control of Mäori health services. Durie argues that the reforms created a dilemma for Mäori.

> 'Privatisation masqueraded as tino rangatiratanga (tribal authority and self determination); biculturalism was confused with partnership; and devolution merely created the illusion of self-determination' (Durie, 1994, p151).

In, my view the reform process and consequences for Mäori required further scrutiny and thus led to my Ph.D. research interest. The lack of examination or analysis on the impact of government policy on Mäori health provision or the social impact of such policy raised several questions: What were the models that influenced government policy since 1983? What was the ideology behind the reforms of 1991 and 1993? Were Mäori influencing mainstream health policy? Was the tremendous growth in Mäori health initiatives an example of Mäori development or their establishment as de facto Crown agents?

From the outset the overall aim of the thesis was to examine government policy, reform of the health sector and the relationship between health services and Mäori from 1983 to 1997. Critical to this is the Treaty of Waitangi, identifying the Treaty partners and the relationship and understanding the relevance of the Treaty of Waitangi to the contemporary health sector.

The intention of the thesis research was not to examine health status or argue that if the Treaty of Waitangi was honoured everything would be fixed and Mäori would no longer experience health disparities. The focus is Crown health policy. Does the Crown comply with its own policies or has it been in breach itself over the period of health reform 1983-1997.

Fundamentally, I have examined the State and its relationship to one group of its citizens, Mäori, as the "other". The New Zealand experience of colonisation is in part different from other British colonies because of the Treaty of Waitangi. The Treaty has been a chance for New Zealand to forge a blueprint for a new society. I personally have experienced the role of an agent of the state as a nurse within the health sector. As part of that role, I began trying to understand the realities of an oppressed and despairing community. Where does the difference in their situation get made? It was not at the individual level. At the state level then, what has been the relationship of the state with the other? This thesis therefore examines the New Zealand health sector, and particularly the recent reforms of it, as one of the fields in which the relationship of the state with the other has been defined and played out.

## Case Studies

Two significant opportunities have contributed to the research documented herein. The first has been the opportunity of the researcher to participate in the 1998 Wai 692 claim to the Waitangi tribunal, first through the preparation of a scoping report, and secondly through commissioned research on behalf of the Tribunal. The second was research into improving Mäori health outcomes commissioned by the National Health Committee in 2000.

The Wai 692 claim is the first health claim to be heard by the Waitangi Tribunal. It expanded and replaced an earlier claim (Wai 473) to the tribunal lodged by one of the claimants in 1994. As such it has provided a unique opportunity, because at the time of the fieldwork for the research (mid 1998 to mid 1999), the key health reform decision-makers were still in Cabinet. The decisions, which the claim challenged, were decisions made by contemporary politicians on both sides of the house, being tested within the Tribunal process.

Contemporary Crown officials were available for oral cross-examination, rather than their predecessors' views needing to be disinterred from a 100-year old tomb. The claim and the accompanying research embodied an unprecedented level of accountability, together with, in the view of some Tribunal officials, unprecedented levels of resistance.

The Wai 692 claim has given the opportunity to look at one community as a case study – from health consumer to Cabinet Minister.

It has involved one Hawke's Bay Iwi, which has made the researcher's job a much simpler one. Ngati Kahungunu have been involved in the issues highlighted by the claim from its inception, so have a lengthy institutional memory in respect of the claim and all issues associated with it. Their enormous cooperation and support, and the link with their regional claim, facilitated the research and claim process enormously.

While the Wai 692 process produced a great deal of primary source material, a further opportunity arose in respect of research for the National Health Committee (NHC), chaired by Professor Mason Durie. The NHC commissioned research into the policy process and its effectiveness in respect of Mäori health. Conducting research with Crown agencies on behalf of a Crown agency opens doors for a researcher that otherwise may be somewhat less penetrable. The opportunity to gather primary source material through the NHC contract was exceptional.

Field research for this thesis took many months. The Wai 692 process involved field research, in both Hawke's Bay and Wellington for about 9 months during the period 1998/99. NHC research took up from February to June of 2000, and involved Crown and other agencies throughout the country.

## Methodology

The research process underlying this dissertation has been the standard approach used by historians. That is, the initial focus has been on primary source material, followed by a widening of the line of enquiry from there to the secondary sources. The primary source material for the research would be predominantly oral history interviews including those key personnel in government involved in the development and implementation of health policy, Mäori health providers and Mäori health professionals working in mainstream health services implementing government policy.

Oral history has been described as giving a voice to the voiceless (Lummis, 1987, p17). In this context the value and purpose of this methodology overcomes lack of formal documentation. The era of recent health reform was dominated by the use

of consultants and public relations companies. The documentation generated by them was not necessarily for public use and consequently not always retained within government and other agencies concerned. With the high turnover of key staff in the health sector, numerous reconfigurations and structural changes the lack of institutional memory in the sector adds to the difficulty in establishing a historical record. Thus oral history interviews with some of the key players and personnel provide in some instances the only information as to how or why a decision was made.

> Oral history in its present form permits the purposeful intervention of historians in collecting the data needed to illuminate particular areas about which too little information has survived from other sources. It is an ideal method for studying the recent past of unorganised workers, domestic life, attitudes and ideology at the grass roots, the experience of childhood or indeed any historical dimension which can be explored through lived experience. In Europe, for example, it is now virtually the only method of fully exploring the many underground struggles against fascism because these were by definition clandestine and often undocumented by those involved (Lummis, 1987, p. 17).

Selection of interviewees for both Wai 692 and National Health research projects occurred in a variety of ways; recommended by key personnel as appropriate to speak to, name came up in archival information or interviews already conducted, current employees or officials of Crown agencies and represented their organisation, representatives of NGO's, individuals identified by comments made in the media and Waitangi Tribunal claimants and individuals identified by claimants. Waikato University Ethics Committee approval was granted December 1999 (see Appendix 4).

There were no standard interview questions for every participant. Some interviewees requested a range of questions or areas of interest from the

researcher prior to giving consent to being interviewed. This was complied with. In other instances the actual interview did not take place until the third or fourth meeting when the interviewee was comfortable with the process.

The oral history interviews have been conducted with:

- a large cross section and range of key Crown officials,
- health care consumers
- officials of a large range of health care entities including NGOs and private providers
- Mäori leadership
- Whanau and hapu of Ngati Kahungunu

A table setting out the interviews follows:

## Table 1: Oral History Interviews

| Entity | Branch | Official & Role | Date |
|---|---|---|---|
| Raukura Hauora O Tainui | | Ramiri Te Hemara-Maipi, Primary Health Care Worker | 25 June 1996* |
| Raukura Hauora O Tainui | | Tutata Matatahi, Primary Health Care Worker | 11 July 1996* |
| Ministry of Health | | Wiremu Manaia | June 1997 |
| New Zealand Medical Association | Hawke's Bay Branch | Dr. Simon Bednarek, President | 13 January 1999 |
| Healthcare Hawke's Bay | | Walter Wilson, Board Member | 14 January 1999 |
| Mäori Women's Resource Centre | Napier | Committee | 19 January 1999 |
| City Medical | Napier | Alan Macintosh, General Manager | 19 January 1999 |
| Taiwhenua | | Bevan Taylor, Chair | 19 January 1999 |
| Healthcare Hawke's Bay | | Wiremu Hodges, ex Mäori Health Manager | 20 January 1999 |
| Labour Party | | Geoff Braybrooke, MP, Napier | 25 January 1999 |
| Hawke's Bay Health Council (since disbanded) | | Brenda Fine and Bernard Thompson | 25 January 1999 |
| | | | |

| | | | |
|---|---|---|---|
| Te Kupenga Hauora | | Te Maari Joe, Business Director | 26 August 1998 & 26 January 1999 |
| Hawke's Bay Ambulance Service | Napier | John Osborne, General Manager | 29 January 1999 |
| Hawke's Bay Ambulance Service | Napier | Barry Howell, Operations Manager | 29 January 1999 |
| Napier City Council | | Neil Taylor, Chief Executive Officer | 5 February 1999 |
| Healthcare Hawke's Bay | | Mark Flowers, Chief Executive Officer | 5 February 1999 |
| Labour Party | Napier | Michael Cullen, Deputy Leader & List MP | 16 February 1999 |
| Independent MP | | Neil Kirton, MP, ex Associate Minister of Health | 20 January 1999 & 17 February 1999 |
| Alliance | | Phillida Bunkle, List MP, Alliance Spokesperson on Health | 16 and 19 February 1999 |
| Napier City Council | | Alan Dick, Mayor | 19 February 1999 |
| Ministry of Health | Te Kete Hauora | Hera Douglass, Policy Analyst | 19 February 1999 |
| Mäori Health Commission | | Wayne McLean, Mäori Health Commissioner | Telephone interview, 9 March 1999 & 10 March 2000 |
| Treasury | CCMAU | Steve Anderson, Principal Adviser, Health | 12 March 1999 |
| Treasury | CCMAU | James Hay, Legal Adviser | 12 March 1999 |
| Te Puni Kökiri | Monitoring and Evaluation | Lisa Davies, Branch Manager | 12 March 1999 |
| Accident Compensation Corporation | | Garry Wilson, CEO Verna Ohia-Gates | 2 March 2000 |
| Platform | | Barbara Anderson, Chairperson | 6 March 2000 |
| Commissioner for Children | | Roger Mclay | 15 March 2000 |
| Capital Coast Health | | Margot Mains, CEO | 15 March 2000 |
| Auckland Healthcare | | Nigel Chee & Simon Royal, Mäori Health Unit | 16 March 2000 |
| Pacific Health | | Ron Dunham, CEO | 17 March 2000 |
| Te Puni Kökiri | Policy | Darne Grant | 20 March 2000 |

| | | | |
|---|---|---|---|
| Health Funding Authority | Clinical Training Agency | Michael Moore, Manager | 22 March 2000 |
| Pegasus IPA | | Mike T | 23 March 2000 |
| Mental Health Commission | | Barbara Disley, Bob Henare, Commissioners | 27 March 2000 |
| Eru Pomare Research Institute | | Paparangi Reid, Director, Vera Keefe-Ormsby, Bridget Robson | 28 March 2000 |
| Treasury | Health Directorate | Nicholas Mays, Dominic Walton | 30 March 2000 |
| Treasury | CCMAU | Steve Anderson | 30 March 2000 |
| Healthcare Aotearoa HCA | | Peter Glensor | 30 March 2000 |
| The Royal New Zealand Plunket Society | | Becky Fox and Angela Baldwin | 30 March 2000 |
| Ministry of Health | Performance Monitoring Branch | Joan Mirkin | 31 March 2000 |
| Health Funding Authority | Mäori Health Group | Rob Cooper, General Manager | 31 March 2000 |
| Ministry of Youth Affairs | | Mereana Ruri, Policy Analyst | 31 March 2000 |
| Canterbury Health | | Richard Webb, CEO | 4 April 2000 |
| Ngai Tahu Development Corporation | | Fiona Pym | 4 April 2000 |
| Te Runanga O Nga Mata Waka | | Norm Dewes, CEO & Linda Ngata | 4 April 2000 |
| Crown Health Association | | Combined meeting of CEOs and Chairs | |
| Ministry of Health | Te Kete Hauora | Ria Earp & Rachel Robson | 5 April 2000 |
| Health Funding Authority | Te Tai Tokerau MAPO | Louise Davis | 6 April 2000 |
| Northland Health | | Ken Whelan, CEO | 6 April 2000 |
| Te Hauora O Te Tai Tokerau | | Edith McNeil | 6 April 2000 |
| Ministry of Health | Safety and Regulation Branch | David Press | 12 April 2000 |
| Work and Income New Zealand | | Angela Wallace | 13 April 2000 |
| Health Funding Authority | Public Health Group | Don Matheson, DDG | 28 April 2000 |
| Health Funding Authority | Personal Health Group | Win Bennett, Mara Andrews | 11 May 2000 |
| Ministry of Women's Affairs | | Lesley Kelly, Policy Analyst | 12 May 2000 |

Additional primary source material has included:

- Transcripts of evidence and cross examination at the Crown hearing of Wai 692
- Media, newspaper cuttings, press releases and media interviews, Crown and Crown agency commissioned reports
- Crown reports
- Crown policy statements
- Departmental reviews
- Crown research
- Submissions to Government Commissions

Methodology used in the research has included a wide ranging survey of the documentary sources, with some restrictions due to access limitations imposed by some of the Crown agencies involved in health service delivery.

## Chapter Outlines

The first chapter introduces the health sector and its reforms, identifies the basis for the author's interest in the research, and the theoretical stance being adopted. . It includes some introductory comments on the Treaty of Waitangi and health. It provides details of the research methods used, including a summary of primary and other source material, and identifies the two major research opportunities that have supported the development of the thesis

The second chapter (Chapter 2 - The Treaty of Waitangi & its role in the Health Sector) provides a background to the Treaty of Waitangi, together with a brief overview of how it is seen in the contemporary context. It puts the argument for Crown responsibilities under the Treaty and draws out the distinctions between Article 2 and Article 3. It provides a historical background to the place of the

Treaty in the health sector, and forms the basis for the Treaty based analysis of the reforms and their impact.

Chapter three provides an historical overview of the New Zealand health sector during the period of reform under review. The chapter starts with the development of the New Zealand Welfare State. The welfare state under pressure leads to a broad overview of the neo-liberal reforms of the 1980s as they impacted on New Zealand society.

Chapter four considers two strong international influences on the last decade of New Zealand reforms, being the changes in the United Kingdom, and the so-called "Oregon experiment." The chapter then focuses on Crown entities, their development and reform, and the broad changes in the mainstream side of New Zealand's health care delivery system. The structural changes that mark much of mainstream health reform are outlined and the resulting entities described.

Chapter five highlights the effect of health reform on the growth in Mäori health service funding and provision. It uses the development of Mäori health providers in the Tainui Iwi as an exemplar for that development elsewhere, much as those providers served as a development model for other Iwi.

Chapter six provides a detailed look at the impact of the 1990s health reform for Mäori, using the specific example of health services to the Ngati Kahungunu Iwi. The chapter is based on work carried out in respect of the Wai 692 claim to the Waitangi Tribunal. The claim was precipitated by the threatened loss of health services associated with the closure of Napier Hospital, but became broadened to

include a wide ranging look at the impact of health reform on Mäori. The chapter provides detailed consideration of the reforms in respect of the Treaty of Waitangi principles as promulgated by the Royal Commission on Social Policy.

The chapter which follows (Chapter 7 - Crown Accountability to Mäori - Monitoring of the Health Sector and its Impact on ) contrasts the Crown's stated intent in health service delivery to Mäori with both its ability to influence outcomes, and with the outcomes themselves. The health policy-making context is reviewed in some detail. The emphasis on Mäori health policy is set within the context of health reform and the fragmentation that it causes. The Crown's attempts (through its agencies) to effectively lead in improving Mäori health status, its stated goal, are examined at many levels. Extracts from transcripts of evidence given by Crown officials to the Wai 692 hearings are used to illustrate the Crown's own evaluation of its success, and to assess the efficacy of the Crown's efforts.

The lack of control and accountability measures, plus the inability of the Crown to monitor (let alone sanction) success or failure, is highlighted. Finally, the chapter concludes by contrasting the health system with the operation of the Resource Management Act (1991) within the territorial local authority sector, a contrast which is heightened by the fact that hospital governance once sat squarely in the local authority sector too.

Chapter eight provides concluding argument for the research, and has some suggestions for improving Mäori health outcomes. The central role of the Treaty

in such improvement is restated. Finally the prospects for improvement are considered. If the ideological conflict between Labour and National viewpoints on health is maintained, the voice and perspective of Mäori is unlikely to get the attention it deserves.

A short postscript brings the impact of the specific reforms up to the present day. It looks at the health service reforms since the period of study, particularly the 1999 Labour-Alliance coalition government reforms that are creating the current health structure. It reviews some of the criticism and debate surrounding those reforms. The inclusion of the Treaty of Waitangi in this legislation, while at first appearing as a step forward, is shown to have been subject to the same ideological conflicts as those noted earlier. Those ideological conflicts are seen to be part of the entire welfare sector, and the fit with the retreat on the government "Closing the Gaps" policy is made explicit.

# CHAPTER 2 - THE TREATY OF WAITANGI & ITS ROLE IN THE HEALTH SECTOR

## Who are the Parties to the Treaty of Waitangi?

The Treaty of Waitangi is a treaty between two parties, the Crown and Mäori. It is a not an uncommon view held by Pakeha that all Mäori should act together, by way of some pan-tribal approach, in order to simplify relationships between the parties, and the resolution of grievances (Alves, 1999). Mäori have a somewhat similar perspective of the Crown. It is important from the outset to clarify what is 'the Crown' and how it is defined for the purpose of this research. The Treaty texts identify the two parties involved in it to be Queen Victoria and Mäori hapu.

> Mäori understood that ultimate authority was vested personally in the Queen. Indeed, the Treaty encouraged them to believe this, regardless of the reality of the constitutional relationship between monarch and government in Britain at the time (Dawson, 2001, p194).

Despite how Mäori perceived the relationship the dynamics shifted in the second half of the 19th century with the responsibilities devolved to the settler government fundamentally altering the status of one of the Treaty partners.

> By 1863, authority on all New Zealand matters, including Mäori affairs, had been transferred to responsible settler government. Mäori resisted this development and attempted to retain a partnership with the Queen. Increasingly, Mäori sought the Queen's protection against the action and inaction of 'the Queen's government' in New Zealand... Despite appeals to the Queen (the Crown), the government in New Zealand was now 'the Crown' (Dawson, 2001, p194).

There is much confusion in the Treaty discourse of what is and who is the Crown. The Crown represents the legal entity of the state. Confusion emerges in the debate when the Crown also includes Mäori in some contexts and not others.

> The fact that the Crown has come to be synonymous with government is a reflection of the fact that New Zealanders in general (and Mäori in particular) do not have that layer of authority which can provide protection from government actions and authority in New Zealand. However, perhaps the most significant injustice is that the government, in assuming the position of the Crown, is playing two roles at once as both protector and accused subjugator of Mäori rights under the Treaty.
>
> The key concern is that governments use the Crown at the expense of the public's understanding of the detail of treaty negotiations and that the symbol protects the present power structure while also determining future possibilities. These implications are particularly serious for Mäori, many of whom ... have an alternative conception of the Crown whose progress in treaty negotiations may be inhibited by the prevailing interpretations of the Crown and the obstacles to future development which these interpretations create. In using 'the Crown' symbol, Ministers were not only sending a message to Mäori that the Treaty was acknowledged, but at the same time were sending a message to others seeking reassurance that ... Sovereignty in New Zealand would continue to reside in the Pakeha system of government (Dawson, 2001, pp194-195).

The term 'the Crown' is open to manipulation dependent on who the parties are. In some instances fragmentation of different Crown agencies roles and responsibilities is used to distance 'the Crown' from its own Treaty responsibilities. In the Wai 692 hearings crown entities themselves denied they were Crown agencies and tried to use statute to distance themselves from 'the Crown'.

> **PROF SORRENSON (Member of the Waitangi Tribunal Hearing Wai 692):** Mr Wilson, just some fairly general questions. First of all, is Healthcare Hawke's Bay an agency of the Crown?
>
> **MR WILSON (Chairman, Healthcare Hawke's Bay):** No, it is a separate registered company in which the Crown are the shareholders. So, I don't know whether that is strictly within the definition of an agency.

**PROF SORRENSON:** Yes, you referred at times to a shareholding Minister. So. One of the Ministers holds a shareholding, or the Crown's shareholding in the company, does it?

**MR WILSON:** Yes. The shares are held by the - equally by the Minister of Finance, and the Minister of Health. So, they are Crown holders.

**PROF SORRENSON:** They are Crown?

**MR WILSON:** They are Crown holders in effect.

**PROF SORRENSON:** Holders. It's a Crown enterprise, isn't it?

**MR WILSON:** Yes.

**PROF SORRENSON:** Who owns the land that the hospitals are sitting on? Is that Crown land?

**MR WILSON:** Yes. It is owned by Healthcare Hawke's Bay. The Company actually owns the land, but if you track through the shareholders, you could say that there is a Crown interest in the land.

**PROF SORRENSON:** Yes; and you've, in a sense, inherited it from the Hospital Board?

**MR WILSON:** Indeed.

**PROF SORRENSON:** Yes. And I think you said that the current members of the board are appointed by the Minister? Is that right?

**MR WILSON:** They are appointed by the Cabinet Appointments and - well, the Appointment Committee, and it seems to be a complicated process, but it's --

**PROF SORRENSON:** Is that a committee of Cabinet?

**MR WILSON:** It is a committee of Cabinet, yes, who makes decisions based on recommendations provided by the Appointments Officer at CCMAU.

**PROF SORRENSON:** So, you can be hired and fired by that committee? Is that right?

**MR WILSON:** Absolutely.

**PROF SORRENSON:** Yes. So, in many ways, you appear to be a Crown - an agency of the Crown. Well, assuming that you are, do you consider it your responsibility to be familiar with the obligations of the Crown, the Treaty obligations of the Crown, under the Treaty of Waitangi Act, the 1975 Act and the 1985 amendment?

**MR WILSON:** Yes, I think it is an obligation to be aware of the principles.

**PROF SORRENSON:** Are you familiar with the jurisprudence of the Treaty principles, and particularly the findings of various Waitangi Tribunal reports on Treaty principles, and the principal judgments of the courts, like the Court of Appeal in the Lands case? Are you personally familiar with them?

**MR WILSON:** No, I am not personally familiar with them. I would rely on advice on those matters.

**PROF SORRENSON:** You would rely on advice?

**MR WILSON:** I would rely on advice.

**PROF SORRENSON:** From what? From your lawyers?

**MR WILSON:** Well, if they were matters, and they principally relate to the ownership of land, and principally relate to matters concerning the use of the land, and on those matters there are agencies of the Crown who provide specific advice.

**PROF SORRENSON:** I see. But, in your operations, you don't appear to be familiar with some of the leading principles of the Treaty?

**MR WILSON:** We actually provide the services according to a contracted arrangement, which includes the references to the Treaty obligations, and that's the level of my understanding (Wilson, 1999, pp309, 310)

The concept of 'the Crown' has been used by successive governments to portray that they are not responsible as the government and that they do not exert the determining influence. The reality is 'the Crown' is an instrument of politics regardless of what political party is in power. The Crown is the Crown is the Crown no matter what it may want to call itself and how it may want to reinvent itself. My position on 'the Crown' is consistent with that adopted by the Waitangi Tribunal. The Crown's many bits and fragments cannot escape the fundamental relationship of Crown with Mäori as determined by the Treaty of Waitangi.

## Why should the State Factor in Mäori Interests?

Non-Mäori New Zealanders have asked the question 'Why should Mäori be treated any differently to Pakeha? (Scott, 1995, p7) In the context of the health sector and health service delivery to Mäori the question could be asked slightly differently with similar purpose. Why should the State promote and support Mäori interests in the health sector?

The Treaty of Waitangi signed in 1840 between Mäori and the British Crown is at the heart of the reason why. The Treaty signalled a commitment between the two parties to a partnership. It provided Mäori with certain rights, privileges and guarantees that they legitimately continue to expect to be upheld and honoured. This ensures Mäori have a unique place in New Zealand society with the rightful expectation that their interests will not only be factored in by the State but also actively protected.

The founding document of New Zealand is the Treaty of Waitangi and was between two defined parties, the British Crown and Mäori as tangata whenua. The Treaty partnership is between the Crown and Iwi and Hapu (Orange, 1987). This is the primary relationship. It was these parties who entered the agreement that is the Treaty of Waitangi. They engaged with each other as sovereign entities and they both sought to satisfy interests in common while protecting separate interests.

The Treaty of Waitangi has two texts, one Mäori and one in English. The English text is not an exact translation of the Mäori text.

> 'The Treaty of Waitangi may be unique in international experience in that it is comprised of two texts, one not a precise translation of the other and each carrying its own cultural expectations, history and tradition' (Kawharu, 1989, p131).

Despite the conflict and debate caused by the different translations, both texts represent an agreement in which Mäori gave the Crown rights to govern and to develop a British settlement, while the Crown guaranteed Mäori full protection of their interests, their status and full citizenship rights.

Professor Sir Hugh Kawharu has translated the Mäori text of the Treaty of Waitangi. His translation of the First Article is

> The Chiefs of a Confederation and the chiefs all also [who] have not entered that Confederation give absolutely to the Queen of England forever the Government of their land.

He translates the Second Article

> The Queen of England arranges [and] agrees to the Chiefs, to the sub-tribes to people all of New Zealand the unqualified exercise of their Chieftainship over their villages and over their treasures all their treasures. But on the other hand the Chiefs of the Confederation and all the Chiefs will sell land to the Queen at a price agreed to by the person owning it and by the person buying it (the latter being) appointed by the Queen as her purchase agent.

The third

> For this agreed arrangement therefore concerning the Government of the Queen, the Queen of England will protect all the ordinary people of New Zealand and will give them the same rights and duties of citizenship as the people of England (Kawharu, 1989, p319).

The significance of the Treaty to Mäori is huge. It goes beyond the defined relationship between Mäori and the Crown. It is in the very recognition of Mäori as a collective whole as the Treaty partner that is unique. The citizenship rights

and duties contained in Article Three effectively created Mäori. Up until the signing of the Treaty Mäori were not a political entity perceived as a collective whole, but consisted of hapu and Iwi groupings that had separate and distinct identities.

The flip side of that is the Treaty also gave the Crown legitimacy. In New Zealand Mäori Council vs Attorney General, Richardson J expressed the view that the Treaty of Waitangi was a solemn compact in which for its part 'the Crown sought legitimacy from the indigenous people for its acquisition of sovereignty and in return it gave certain guarantees. That basis of compact requires each party to act reasonably and in good faith towards the other.' In the context of Government action under the Treaty, he found that 'The concept of the honour of the Crown also has continuing expression... in the international law doctrine of good faith' (Kawharu, 1989, p128).

With the agreement to Article Three, tangata whenua also gained citizenship rights as Mäori. It did not replace the individual rights and obligations that tangata whenua had to their Hapu and Iwi. As tangata whenua their identity relied upon whom they belonged to and the rights and obligations that flowed from this. The language of the culture reflected this in that individuals identified and were identified on the basis of whakapapa, and the whenua from which they came, with all its symbols of identification (maunga [mountains], moana [lakes and oceans], awa [rivers])" (NZLS, 1999, p18).

The guardians of the Treaty have been Mäori who have retained the original vision of the undertakings made in the Treaty of Waitangi. What has sustained the vision is the belief of their individual and collective sovereignty that derives from their status as tangata whenua. It is the mana of tangata whenua status as identified and confirmed in the 1835 Declaration of Independence (Kelsey, 1990) and again in the Treaty of Waitangi that creates a different expectation for Mäori in contrast to that of non-Mäori New Zealanders. It is te tino rangatiratanga o te iwi Mäori, the absolute authority of the Mäori people collectively over their lives and resources that is the defining difference.

Mäori have consistently upheld their right to assert tino rangatiratanga.

> The Treaty of Waitangi ... guaranteed that the rangatiratanga of Mäori would be maintained and that the ritenga or basic threads of Mäori society would be promoted. These concepts, crucial to the mana or sovereign prestige of Mäori, are the tahuhu or ridge-pole of Mäori self-determination. They are the 'singular context' which define the authority of Mäori to determine the destiny of Mäori. They arise not from a recent minority place in New Zealand, but from time immemorial as tangata whenua. They are not dependent upon definition and recognition by the Crown or Pakeha international law, but are rights shaped by the place of our tipuna, our ancestors, in this land... 'The source of our rights is that, like the kauri, we are grounded here, we were nurtured here, we are the people of this land.... and we know that the Treaty protected our place, covenanted our rights' (Te Ataria, in Kelsey, 1990, p6).

The Declaration of Independence predates the Treaty by five years. It focused strongly on the rights of tangata whenua to exercise tino rangatiratanga and have autonomy over their own affairs. It clearly stated a position of how Mäori viewed their independence and that sovereign power would remain with them.

In 1835 thirty-four northern chiefs and the British Crown, represented by Resident Busby executed the Declaration of Independence of New Zealand. The English text of the declaration reads:

> We the hereditary chiefs and heads of the tribes (tino rangatira) of the Northern parts of New Zealand ... declare the Independence (rangatiratanga) of our country, which is hereby constituted and declared to be an Independent State (wenua rangatira), under the designation of the United Tribes of New Zealand. All sovereign power (kingitanga) and authority (mana) within the territories of the United Tribes of New Zealand is hereby declared to reside entirely and exclusively in the hereditary chiefs and heads of tribes (tino rangatira) in their collective capacity, who also declare that they will not permit any legislative authority separate from themselves in their collective capacity to exist, nor any function of government (kawanatanga) to be exercised within the said territories, unless by persons appointed by them, and acting under the authority of laws regularly enacted by them in Congress assembled (Kelsey, 1990, p7).

An invitation was extended to the southern tribes to join the confederation and the last signature added to the Declaration of Independence occurred in July 1839 making a total of fifty-two chiefs.

Less than one year later the Treaty of Waitangi was signed and affirmed Mäori tino rangatiratanga, over their whenua, kainga and taonga. In the Treaty 'independence' was translated in the English text as 'full, exclusive and undisturbed possession' of their lands and estates, forests, fisheries, and other properties which they wished to retain in their possession.

Sir James Henare, kaitiaki of the Treaty of Waitangi and member of the Council of Chiefs of Ngapuhi, defined the meaning of taonga as basically the Mäori way of life, in contrast to the concept of Mäoritanga.

> 'Te tino rangatiratanga' as used in the Treaty means the Chieftainship over all their taonga, tangible or intangible. Things animate or otherwise.

> 'Taonga' are tangible and intangible culture, language, art, craft, lands. That is the Mäori way of life, 'Mäoritanga' being expressed by way of their art, their craft, their language, their customs, their traditions. When their 'taonga' were to be protected by the Treaty the people trusted that the Mäori way of life would also continue and be guaranteed (Henare in Kelsey, 1990, p10).

As Sir James described it the Treaty was a guarantee of the Mäori way of life with the added benefits which Pakeha presence could bring. Sir James stated that:

> Because of the Treaty the Mäori believe, right to this day, that they are equal partners and they know from experience that it's not so. But right to this day, and those Chiefs that I had the great privilege of being associated with, Runanga o te Tiriti o Waitangi, and they always said that, that they had equal rights. That is why they signed the Treaty. And lots of people and including some historians, Lindsay Buchanan and these people, seem to infer that those Chiefs didn't know what they were signing. They knew what they were signing, reading the Mäori version. But, when it came to sovereignty in the English version what in fact they did sign was giving away all their mana and everything else to the Queen of England. Which they never believed and never intended to do so. And that's quite plain from signing the Mäori version. That it was the Government and the governments of their land. Not sovereignty (Henare in Kelsey, 1990, p11).

The Mäori perspective is at odds with the prevailing ideology of mainstream New Zealand who advocate the one New Zealand argument. The general ignorance of most Pakeha concerning the continuing history of the Treaty within Mäoridom has been commented on in several Waitangi Tribunal reports:

> The Treaty of Waitangi has always assumed great importance in the eyes of the Mäori. He [sic] believes that by the solemn agreement made with the Queen of England the peaceful colonisation of New Zealand became possible ... The European on the other hand generally regarded the Treaty as an historical event which does not have much impact on modern New Zealand. This view springs largely from the judicial decisions in cases when the legal consequences of the Treaty have been in question and which have led to the conclusion that it has no place in New Zealand law (Waitangi Tribunal, Wai-4, 1984, para 5.1&5.2).

Mäori have consistently honoured their commitment to the Treaty by not repudiating the legitimacy of the Crown. Mäori have not entered into acts of

rebellion. Their armed struggle has been limited to self-defence when the Crown has acted to threaten their rangatiratanga. Mäori have consistently worked within the political and legal system to seek redress from the Crown for breaches of the Treaty. They have approached the Queen, used the Court processes, established Mäori political parties, and most recently used both the Waitangi Tribunal and direct negotiation with the government of the day to secure redress (Walker, 1990, p160-185, Kelsey, 1990, p210-237, Ward, 1999, p172).

Pakeha perceptions of the Treaty have generally focused on the historical events of 1840 and the great benefits colonisation has brought to Mäori. There is no recognition by non-Mäori that the Crown's commitment to the Treaty has shifted since 1840. Contemporary comments and documents in the three decades after signing suggest that the treaty was influential on some decisions and legislation. Governor Fitzroy commented in 1844 on the significance of the Treaty and some of the perceptions at the time of signing:

> That the natives did not view all its provisions in exactly the same light as our authorities is undoubted: but whatever minor objections may be raised, the fact is now unquestionable that the loyalty, the fidelity and cooperation of any natives in New Zealand, has hitherto depended mainly on their reliance on the honour of Great Britain in adhering scrupulously to the Treaty of Waitangi – the Magna Carta of New Zealand (cited in Kawharu 1989, p73).

Representatives of the Crown were expected to uphold and comply with the Treaty obligations. Governor Fitzroy instructed his successor George Grey:

> 'You will honourably and scrupulously fulfil the conditions of the Treaty of Waitangi' (cited in Kawharu 1989, p73).

A private letter written in 1848 by the then British Prime Minister Sir Robert Peel suggests pragmatic reasons, such as the size and vulnerability of the settler colony in contrast to the Mäori population, encouraged Treaty recognition at the time:

> If the obligations of good faith vary with the military skill and prowess of the parties to a Treaty, the New Zealanders [that is, the Mäori] have put in a claim to be respected which it has become prudent on our part to recognize (cited in Kawharu 1989, p75).

The English texts of the Treaty have been taken into account in the drafting of legislation in the 19th and 20th century. The English wording on Crown pre-emption in Article 2, and the understanding that this entailed a Crown monopoly to purchase Mäori land, was incorporated in the Land Claims Ordinance 1841 and the Native Land Purchase Ordinance 1846. The English wording of Article 3 was relied upon to justify the Native Rights Act 1865. The reference to fisheries in Article 2 was explicitly mentioned in the Fish Protection Act 1877. The Waitangi Day Act 1960 provided that 6 February is 'a national day of thanksgiving in commemoration of the signing' and that it might be a substitute for a provincial anniversary statutory holiday. It later became a national holiday (Kawharu 1989, p77).

The Treaty's lack of legal status and recognition has been a great source of frustration to Mäori. The Waitangi Tribunal in its 1983 Te Atiawa (Motunui) Report commented that 'Mäori people have persistently pleaded the Treaty in the Courts but without success' (Waitangi Tribunal, Wai-6, 1983) and they provided fourteen examples of superior court decisions from 1847 to 1977.

Yet in an opinion given on the Treaty of Waitangi in 1848, the noted jurist Joseph Phillimore commented:

> Of the validity of this Treaty no one at all versed in the science of public law can entertain a doubt. It possesses all the ingredients which Writers on the Law of Nations deem essential to establish the validity of such a compact... (Kawharu, 1989, p126).

Phillimore's comment endorsed the legal validity of the Treaty in international law at the time of signing. Despite such views and opinions the Crown has resisted and refused from the second half of the 19th century to give the Treaty status domestically. A long line of judicial decisions has reinforced the opinion that the Treaty is not part of New Zealand law. The infamous example is that of Chief Justice Prendergast, in an 1877 case brought by a Mäori tribe to void a Crown grant of land, declared the Treaty to be, ' A simple nullity. No body politic existed capable of making cession of sovereignty, nor could the thing itself exist' (Palmer, 1992, p72). This view is now recognized as having been based on a wrong approach to international law that persisted for a long time (Williamson J in Dawson, 2001).

For Mäori the very lack of legal status is a breach of the undertakings made and entered into between the two Treaty partners in 1840. As Chief Judge Durie has stated when commenting on the Treaty's lack of legal status 'Of course no one told the Mäoris that would be so when the Treaty was signed, or that partnership would be conditional on the affirmation of a democratically elected parliament' (Durie in Kelsey, 1990, p220).

Between the lack of legal status and the inconsistency of the Crown's position it is not surprising that there has been a widening gap between Mäori and Pakeha expectations of the Treaty. Richardson J, sitting in the Court of Appeal (cited in Kawharu, 1989), has commented:

> ... the Treaty has never been legislatively adopted as domestic law in New Zealand. And any readings of our history brings home how different the attitudes of the Treaty partners to the Treaty have been for much of our post 1840 history: on the one hand, relative neglect and ignoring of the Treaty because it was not viewed as of any constitutional significance or political or social relevance; and on the other, continuing reliance on Treaty promises and continuing expressions of great loyalty to and trust in the Crown. It is only in relatively recent years and as reflected in the Treaty of Waitangi legislation itself that the lagging partner has started seriously addressing these questions (Kawharu, 1989, p76).

So if the argument that the Treaty is the reason why Mäori interests should be factored in by the Crown was rejected that in itself is not sufficient to ignore the State's obligation to Mäori. There are ample precedents within many Western jurisdictions that acknowledge that a colonising State has obligations to remedy the negative effects it has had on an indigenous people. The United States alone makes special provision for indigenous health services, indigenous gambling rights, land, and other natural resources (Prucha, 1990).

The Crown has a responsibility to Mäori due to the Treaty commitments entered into and as the coloniser of the indigenous people. International law has recognized the Treaty as legally valid and an international Treaty of cession. International arbitral tribunals have twice indicated that the Treaty of Waitangi was a valid and effectual international treaty of cession.

In Rogers & Co, an arbitral decision under the Convention between Great Britain and the United States of 8 February 1853, the British Commissioner, Hornby, held:

> On the 6th of February 1840, the Treaty of Waitangi was concluded, by which the Islands of New Zealand were ceded to Great Britain... (Kawharu, 1989, p125)

He added that 'the cession was accepted by Governor Hobson and Sir G.Gipps'.

The Anglo-American arbitral tribunal in the William Webster case reached the same conclusion in 1925. The terms of the Treaty established the expected relationship between the indigenous people and the Government. Failure by the Government to honour the terms of the treaty may be seen as a denial of the international law obligation to ensure treatment which is equal in fact as well in law.

The Treaty of Waitangi and the modern understanding of its principles represent part of the 'public law' by which the relationship between Mäori and the Crown is legally expressed. International law, including norms relating to indigenous peoples and to human rights, is imported into this public law to a limited but significant extent (Kawharu, 1989).

The rights of indigenous people as determined by the United Nations, who have historically advocated to protect human rights, would place an obligation on the Crown to recognise the unique rights of Mäori as tangata whenua. Internationally the rights of indigenous people have been recognized by organizations such as the United Nations and affiliated working parties, International Labour Organisation (ILO) and UNESCO.

Critical to the debate on the rights and recognition of indigenous peoples is the very definition of what or who are indigenous people. In 1989 the International Labour Organisation adopted a treaty dealing with indigenous rights; the

Convention Concerning Indigenous and Tribal Populations in Independent Countries: Convention 169. The Convention defined indigenous peoples as:

> (a) tribal peoples in independent countries whose social, cultural and economic conditions distinguish them from other sections of the national community, and whose status is regulated wholly or partially by their own customs or traditions or by special laws or regulations;
>
> (b) peoples in independent countries who are regarded as indigenous on account of their descent from the populations which inhabited the country, or a geographical region to which the country belongs, at the time of conquest or colonisation or the establishment of present state boundaries and who, irrespective of their legal status, retain some or all of their own social, economic, cultural and political institutions.

The ILO Convention also notes that "self-identification as indigenous or tribal shall be regarded as a fundamental criterion for determining the groups to which the provisions of this Convention shall apply" (Te Puni Kökiri, 1994, p10).

The Declaration on the Right to Development, adopted by the United Nations Assembly December 1986 and supported by New Zealand took a position that upheld the aspirations of indigenous and colonised peoples. It encompassed the contemporary view of tino rangatiratanga. Relevant provisions of the Declaration included:

> Article 1(1) 'the right to development is an inalienable human right by virtue of which every human person and all peoples are entitled to participate in, contribute to and enjoy economic, social, cultural and political development, in which all human rights and fundamental freedoms can be fully realised....
>
> Article 3(1) 'States have the primary responsibility for the creation of national and international conditions favourable to the realisation of the right to development...
>
> Article 10 'Steps should be taken to ensure the full exercise and progressive enhancement of the right to development, including the formulation, adoption and implementation of policy, legislative and other measures at the national and international levels' (UN, 1986).

The Waitangi Tribunal in its 1988 report on the Muriwhenua Fisheries claim noted 'That all peoples have a right to development is an emerging concept in international law following the Declaration on the Right to Development' and referred to its possible application to indigenous peoples (Kawharu, 1989, p139).

In its 1987 report on Indigenous Peoples, the Independent Commission on International Humanitarian Issues said:

> At the conceptual level, the Working Group [on Indigenous Populations] should help clarify specific details relevant to the indigenous in the application of the 'right to development' as elaborated in the specific General Assembly resolution. We believe that, in the case of the indigenous, the 'right to development' has a special historical and substantive significance (Kawharu, 1989, p141).

The ILO convened a meeting of experts in 1986 to begin the revision of the ILO Convention 107 on Indigenous and Tribal Populations, which concluded:

> 2. Indigenous and tribal peoples should enjoy as much control as possible over their own economic, social and cultural development.

A provision of these terms was included in the revised Convention and added that, 'The indigenous and tribal peoples concerned should have the right to decide their own priorities for the process of development as it affects their lives, beliefs, territories, institutions and spiritual well being...' (Kawharu, 1989, p142).

The United Nations World Conference to Combat Racism and Racial Discrimination urged States to recognize the rights of indigenous people. 'To carry on within their areas of settlement their traditional structure of economy and way of life; this should no way affect their right to participate freely on an equal

basis in the economic, social, and political development of the country...'

(Kawharu, 1989, p147).

In 1990 the United Nations circulated a draft of the Declaration on the Rights of Indigenous Peoples to the international community for comment. The Declaration is a comprehensive document consisting of nine parts and forty-five Articles. Part One outlines the international provisions to protect and uphold the rights of the indigenous.

> Article 1
> Indigenous peoples have the right to the full and effective enjoyment of all human rights and fundamental freedoms recognized in the Charter of the United Nations, the Universal Declaration of Human Rights and international human rights law.
>
> Article 2
> Indigenous individuals and peoples are free and equal to all other individuals and peoples in dignity and rights, and have the right to be free from any kind of adverse discrimination, in particular that based on their indigenous origin or identity.
>
> Article 3
> Indigenous peoples have the right of self-determination. By virtue of that right they freely determine their political status and freely pursue their economic, social and cultural development.
>
> Article 4
> Indigenous peoples have the right to maintain and strengthen their distinct political, economic, social and cultural characteristics, as well as their legal systems, while retaining their rights to participate fully, if they so choose, in the political, economic, social and cultural life of the State.

Other relevant Articles

> Article 7
> Indigenous peoples have the collective and individual right not to be subjected to ethnocide and cultural genocide, including prevention of and redress for:
>
> Any action which has the aim or effect of depriving them of their integrity as distinct peoples, or of their cultural values or ethnic identities;
> Any action which has the aim or effect of dispossessing them of their lands, territories or resources;

Any form of population transfer which has the aim or effect of violating or undermining any of their rights;
Any form of assimilation or integration by other cultures or ways of life imposed on them by legislative, administrative or other measures;
Any form of propaganda directed against them.

Article 8
Indigenous peoples have the collective and individual right to maintain and develop their distinct identities and characteristics, including the right to identify themselves as indigenous and to be recognised as such.

Article 19
Indigenous peoples have the right to participate fully, if they so choose, at all levels of decision-making in matters which may affect their rights, lives and destinies through representatives chosen by themselves in accordance with their own procedures, as well as to maintain and develop their own indigenous decision-making institutions.

Article 20
Indigenous peoples have the right to participate fully, if they so choose, through procedures determined by them, in devising legislative or administrative measures that may affect them.

States shall obtain the free and informed consent of the peoples concerned before adopting and implementing such measures.

Article 22
Indigenous peoples have the right to special measures for the immediate, effective and continuing improvement of their economic and social conditions, including in the areas of employment, vocational training and retraining, housing, sanitation, health and social security.
...

Article 23
Indigenous peoples have the right to determine and develop priorities and strategies for exercising their right to development. In particular, indigenous peoples have the right to determine and develop all health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions (UN, 1990).

In 1993 the New Zealand government sought the opinion of tangata whenua on the draft Declaration on the Rights of Indigenous Peoples through consultative hui and submissions. The Draft Declaration intentions support Mäori aspirations to assert tino rangatiratanga. In the international context it is perceived as a

legitimate right. In the context of the United Nations those are rights that Mäori as indigenous peoples have an entitlement to assert and have recognized. The New Zealand government has yet to sign the Declaration on the Rights of Indigenous Peoples.

While the aspirations of Mäori as indigenous people with rights is upheld by Human Rights groups there is no obligation on the State to recognize such rights. There is a range of responses to Mäori requests to have the Treaty honoured and their Treaty rights recognized. The relationship Pakeha have had with the Treaty could be described as conflicted, inconsistent and dishonest. Crown leadership has appeared at times to do little to encourage it to be otherwise (Kelsey, 1990, Dawson 2001).

What recognition there has been could be described as backhanded. Historically, Treaty recognition has focused predominantly on the actual day of signing and the events that took place in 1840. It has been more comfortable to look to the past and focus on the actual event than get to grips with the contemporary reality of the Treaty.

Events of the last three decades in New Zealand's social history have contributed to a shift in public opinion surrounding the Treaty. The 1970s saw the rise of Mäori protest action that focused on the Treaty and challenged the Crown's lack of recognition. Significant events included the march on Parliament of the Mäori Lands Right movement with 30,000 supporters that demanded a moratorium on

the alienation of the remaining Mäori land, and land occupations of disputed land such as Bastion Point, Raglan and Awhitu.

Other contributors have been the Waitangi Tribunal and its role in the examination of New Zealand's colonial history. Initially the Tribunal was to only hear claims of Treaty breaches after 1975 when the Act came into force. The Treaty of Waitangi Act 1975 also required the Tribunal to take into account the principles of the Treaty and gave it statutory authority to decide what those principles were. In 1985 the Treaty of Waitangi Amendment Act was passed to give the Waitangi Tribunal retrospective power to 1840.

As a result Mäori claims on the property rights of physical resources such as land and fisheries began to receive long overdue attention. Furthermore, a key challenge to the corporatisation process under the State Owned Enterprises Act 1986 (NZMC v AG, 1987 1 NZLR 641) had set some small limits (Kelsey, 1990) on the Labour government's ability to ignore the Treaty of Waitangi in its public service restructuring and reform. However health, education, welfare, and housing had received virtually no consideration at all, and their relevance to the Treaty of Waitangi remained largely unexplored (Durie, 1998).

A combination of these factors led to increased pressure for the Government to examine social policy from a Treaty perspective. In 1985 the Standing Committee on Mäori Health recommended that the Treaty of Waitangi be regarded as a foundation for good health. 'The parent body, the New Zealand Board of Health, immediately responded in a positive way and itself recommended that 'All

legislation relating to health should include recognition of the Treaty of Waitangi' (Durie, 1998, p81).

Despite the above recommendation legislation specific to the health sector 8 years later had minimal reference to Mäori. The 1993 Health and Disability Services Act provided the direction for how the health sector would be reformed. Section 8 of the Act refers to the ability of the Minister of Health to give to a purchaser written notice of the Crown's social and other objectives. These objectives include 'the special needs of Mäori and other particular communities or people for those services' (Health and Disability Services Act, 1993, Section 8). The Act does not contain either a Treaty reference or specific Mäori health objectives.

Another forum at the time that explored the Treaty and its relevance to New Zealand society was the Royal Commission on Social Policy. The Royal Commission reported back to the Government its findings in 1988 on its examination of the standards of fairness and the foundations of New Zealand's society and economy. The terms of reference stated:

> The Royal Commission will inquire into the extent to which existing instruments of policy meet the needs of New Zealanders, and report on what fundamental or significant reformation or changes are necessary or desirable in existing policies, administration, institutions or systems to secure a more fair, humanitarian, consistent, efficient and economical social policy which will meet the changed and changing needs of this country and achieve a more just society (Royal Commission on Social Policy, 1987, p1).

They also included the principles of the Treaty of Waitangi. 'The Treaty of Waitangi is an established foundation of New Zealand's society and economy and the application of its principles is one of the major tasks facing the Royal Commission on Social Policy' (1987). The conclusion that the Royal Commission

on Social Policy reached on the Treaty of Waitangi and its role in New Zealand society was:

> The Commission believes that the Treaty is always speaking and that it has relevance to all economic and social policies. Not only must the past be reviewed in light of its principles, but the Treaty's promise must also be seen as fundamental to those principles which will underline social wellbeing in years to come (Durie, 1994, p84).

The Royal Commission on Social Policy recommended (1987) three principles relevant both to social policy and the Treaty of Waitangi: partnership, participation, and protection.

The Royal Commission also referred to the Appeal Court litigation between the NZ Mäori Council and the Crown (NZMC v AG, 1987 1 NZLR 641) over the State Owned Enterprises Act and the comments made about Treaty partnership.

> The Appeal Court Judges who heard the case placed emphasis on the Treaty as a partnership requiring "the utmost good faith" and a need for the partners to act reasonably towards each other. The partnership was seen to create responsibilities, including the active protection of Mäori lands and waters by the Crown and, in turn, loyalty to the Queen and her Government by Mäori people (Royal Commission on Social Policy, 1987, p15).

The Royal Commission took the view and reinforced that the Treaty's relevance could not be excluded from the range of Government policies. This was at odds with the Treasury conclusion that the Treaty was 'silent, as in respect of employment, incomes, and economic development' (Durie, 1998, p85). The Commission rejected the Treasury position. Precedents had been set by the Government and Crown agencies that indicated that Treasury was out of step with some of the Crown's own initiatives and attempts to address the contemporary Treaty issues.

The State Owned Enterprises Act 1986 has an explicit Treaty of Waitangi reference that provided the sole constitutional impediment to privatisation and radical government reform of State assets that occurred in the ensuing period. Section 9 of the Act states 'Nothing in this Act shall permit the Crown to act in a manner inconsistent with the principles of the Treaty of Waitangi'.

The Labour Government Cabinet in 1986 agreed that "all future legislation referred to Cabinet at the policy approval stage should draw attention to any implications for recognition of the principles of the Treaty of Waitangi" (Royal Commission on Social Policy, 1987, p15). It also recommended that government departments should consult with Mäori on significant matters as well as assessing financial and resource implications arising from Treaty considerations.

The Department of Health was one of the first responsive government departments to the Government suggestion. In 1986 in a circular memorandum from the Director-General of Health, Dr George Salmond, to the Hospital Boards and Area Health Boards, he noted that the Treaty had special significance and recommended that its principles be integrated into the health services. He stated the Department's views as:

> For the Department of Health, the Treaty has special significance. Concepts of health are firmly based in Mäori culture (which according to the Treaty has a right to official recognition and protection) and Mäori people have a right to appropriate services - funded through our health system. The Department accepts this view which is in accord with the WHO principles set out in the Alma Ata Declaration of 1978 on Primary Health Care (Durie, 1998, p85).

The Ministerial Advisory Committee on A Mäori Perspective published a report, Puao-te-ata-tu, in 1986 which examined the structures, practices and processes of

the Department of Social Welfare as they related to Mäori. The Department later made a submission to the Royal Commission, which stated that 'all State agencies will have to come to terms with their responsibilities under the Treaty of Waitangi' (Durie, 1998, p85).

While some Crown agencies recognized their Treaty partnership responsibilities and obligations there was no uniform or standard approach throughout Crown entities or within the Crown itself. One attempt to address this was the Labour Cabinet's 1989 "Principles for Crown Action on the Treaty of Waitangi". This initiative was to get some consistency on how the Crown proposed to act on Treaty issues. The intent was to state both the Crown's rights and obligations in a balanced way.

Geoffrey Palmer, former Prime Minister, Attorney General and Minister of Justice has described the purpose of the Principles as:

> There was no intention on my part or the Government's to rewrite the Treaty. And the document did not do this. There did need to be some specificity about what we were doing and what we were not doing. Where did the Crown stand? The Treaty is not a self-executing document. It does not render up plain meaning to current issues in the way that statutes sometimes do. It is vague and uncertain. When you are running a Government it is not enough to tell the officials to follow the Treaty. They need more clarity than that, especially where valuable economic assets are being negotiated. I wanted a clear set of principles which would be applied by the whole government system. I also wanted a statement that could be given to the public which set out in plain terms the principles on which the government was acting. I wanted the principles on which we were acting rigorously thought through and stated. That was achieved and the statement was used later as the base for the decisions we took (Palmer, 1992, p85).

The principles were:

> The Kawanatanga Principle – The Principle of Government

The first Article of the Treaty gives expression to the right of the Crown to make laws and its obligation to govern in accordance with constitutional process. This sovereignty is qualified by the promise to accord the Mäori interest specified in the second Article an appropriate priority.

The Rangatiratanga Principle – The Principle of Self Management

The second Article of the Treaty guarantees to Iwi Mäori the control and enjoyment of those resources and taonga which it is their wish to retain. The preservation of a resource base, restoration of iwi self-management, and the active protection of taonga, both material and cultural, are necessary elements of the Crown's policy of recognising rangatiratanga.

The Principle of Equality

The third Article of the Treaty constitutes a guarantee of legal equality between Mäori and other citizens of New Zealand. This means that all New Zealand citizens are equal before the law. Furthermore, the common law system is selected by the Treaty as the basis for that equality, although human rights accepted under international law are incorporated also.

The third Article also has an important social significance in the implicit assurance that social rights would be enjoyed equally by Mäori with all New Zealand citizens of whatever origin. Special measures to attain that equal enjoyment of social benefits are allowed by international law.

The Principle of Co-operation

The Treaty is regarded by the Crown as establishing a fair basis for two peoples in one country. Duality and unity are both significant. Duality implies distinctive cultural development and unity implies common purpose and community. The relationship between community and distinctive development is governed by the requirement of cooperation which is an obligation placed on both parties to the Treaty.

Reasonable cooperation can only take place if there is consultation on major issues of common concern and if good faith, balance, and commonsense are shown on all sides. The outcome of reasonable cooperation will be partnership.

The Principle of Redress

The Crown accepts a responsibility to provide a process for the resolution of grievance arising from the Treaty. This process may involve courts, the Waitangi Tribunal, or direct negotiation. The provision of redress, where entitlement is established, must take account of its practical impact and of the need to avoid the creation of fresh injustice. If the Crown demonstrates commitment to this process of redress then it will expect reconciliation to result (Palmer, 1992, p85, 86).

Palmer believed that the principles were an effective guide for the Crown as Treaty partner in its dealings with the Mäori Treaty Partner.

Effectively, every new government has been able to reinterpret the Treaty in line with its own ideological and political imperatives, a 'Crown monologue' (Dawson, 2001, p193). The "Crown" as a consistent Treaty partner with whom Mäori can hold dialogue, has degenerated into a seesawing process between parties competing for government, rather than that consistent partner. Mäori have been obliged to react to unilateral change imposed by governments who believe a democratic mandate is the only legitimacy that they need (Dawson, 2001).

The disparity between Mäori, collectively and individually, and other New Zealanders highlights the degree to which Mäori have been disadvantaged by this process. The health reforms in the period covered by this study provide an illustration of its impact.

## The Treaty of Waitangi, The Crown and Mäori Health

The role of the Treaty of Waitangi in respect of public provision of health services is not a new issue. As noted the Department of Health was addressing the issue over 15 years ago. There have been policy guidelines for Boards and health management on their Treaty responsibilities and the implications in the delivery of health care for over a decade.

In 1995 the Public Health Commission stated its understanding of the Treaty and its applicability to health service delivery as follows:

> The clear direction of Te Ara Ahu Whakamua Hui (Te Puni Kökiri, 1994) was that the fundamental base of any relationship between Mäori and a Crown agent should be the Treaty of Waitangi. It is a living document which recognises the tangata whenua (indigenous people) status of Mäori and establishes an ongoing relationship between Mäori and the Crown (Public Health Commission, 1995, p13).

The Ministry of Health, in its 1994 publication Kia Whai te Maramatanga, summarised the implications of the Treaty as follows:

| | |
|---|---|
| Article I | Consultation |
| Article II | Absolute sovereignty |
| Article III | Partnership and equality |

Article One sets out the constitutional basis for the system of government in New Zealand. It is on the basis of the relationship with Iwi Mäori as tangata whenua that the Crown must consult with Mäori. Thus, in the health context Mäori have a legitimate expectation to be both consulted with and involved in the significant decisions which effect the planning, funding, and delivery of health services to them.

> The Treaty contains within it specific obligations which require the Government, as Treaty partner, to address the inequitable position of Mäori. ... This carries with it specific duties to consult with Mäori in the development of government policies and programmes (Public Health Commission, 1995, p13).

Article Two confirms the right of Mäori to control their own property, resources and destiny, within those rules necessary for the operation of the state. Non-material assets including health and well being are included in those ownership rights.

> There were reminders from kuia and koroua that Mäori wellbeing was the result of a complex set of relationships which included social, economic, political, cultural and spiritual factors (Pomare et al, 1995, p26).

The government, in its explicit funding of Mäori kaupapa, or (provided) by Mäori for Mäori services, recognises the principle of tino rangatiratanga over matters of health.

Dr Paparangi Read also insists on the significance of Article Two in respect of intangible resources:

> Article 2 of the Treaty is important in terms of resources. It guarantees protection of resources, people resources, natural resources, intangible resources – head space which is Mäori. Unless we take care to actively protect the survival of that head space, the natural resources, the human resources, we are not honouring the Treaty (Reid, 1989, p26).

According to Mason Durie,

> Health professionals could have unwittingly contributed to an undermining of these values [integrative Mäori conception of health] (referred to in Article 2) by assuming leadership roles that diminished the authority of tribal leaders and chiefs. The treaty guaranteed to tribes the right to determine and control their own villages and treasures: it did not expect that doctors or social workers would have higher order claims on child care or the care of the elderly (Durie, 1989, 283-5).

Article Three says that Mäori have the same rights as other New Zealand citizens, in addition to their rights under Articles One and Two of the Treaty. In the health service context, this article guarantees Mäori both an equitable use of health services, and equity of health outcomes. The fact that Mäori are higher than average users of health services does not release the Crown from the obligation to ensure their health status is as good as that of other citizens. In fact, their poorer than average health status is the contributor to their higher than average utilisation. Mason Durie argues in respect of mental health that:

> Good (mental) health is not compatible with unemployment, demeaning and unrewarding work, negative experiences at school and powerlessness. Neither is it consistent with article three of the Treaty of Waitangi with its guarantee of equality between Mäori people and other New Zealanders...By almost any indicator, Mäori participation in society and the economy is low and disparities between Mäori and non-Mäori remain

> at unacceptably high levels. Poor (mental) health is a not unexpected consequence (Durie, 1999, p5-12).

Pomare et al. (1995, p27) argue that health and the Treaty have been linked from the moment of its signing:

> The Treaty has special relevance to health. Firstly, the wellbeing of residents, and some would argue particularly Mäori, was an intention of the Treaty noted both in Normanby's instructions to Hobson and in the preamble to the Treaty. This is reinforced by the health implications of the various articles including processes of good government, self-determination and development of iwi resources, as well as participation and equity.

## Recent Government Response to the Treaty and Health

From 1986, the Department of Health began informing Hospital Boards and the then developing Area Health Boards of their Treaty of Waitangi responsibilities and the implications for Mäori health. The Department's memorandum in 1987 specifically stated that it had "notified districts and board offices that workshops would be held to assist them to understand the Treaty and its implications for the health services" (Dept. of Health, 1987).

The Department of Health (1987) defined two aspects of the Treaty as having implications for the provision of health services and Mäori health. These were the concept of partnership and the protection of taonga. Partnership was described in the following terms:

- partnership can occur at all levels of policy making by the sharing of power and decision making, satisfactory consultation and the inclusion of a cultural perspective in policies.
- partnership can refer to the process of drafting, implementing and monitoring of legislation.
- partnership is about the manner in which representation is ensured at all levels of administration.
- partnership concerns the allocation of resources.

- partnership extends to the provision of social services and the types of services available.
- partnership challenges the diverse, ethnic and cultural groups in New Zealand to consider their relationships with the tangata whenua.
- partnership requires opportunity for partners to regularly review their relationship and to plan jointly for the well-being of all New Zealanders (Dept. of Health, 1987).

The Department of Health described the concept of partnership as the core issue in honouring the Treaty. The first principle of the kaupapa of the Department stated that it intended "to recognise the Treaty of Waitangi in all activities undertaken" (Dept. of Health, 1987).

The memorandum from the Department on Treaty responsibilities for Area Health Boards was clear on why Boards needed to be more proactive in honouring their Treaty obligations and how this would be demonstrated:

> To fulfil the requirement to honour the Treaty of Waitangi, Mäori people, particularly the tangata whenua in board areas, need to be an integral part of the consultation and planning processes. Boards will need therefore to identify and liaise with local Mäori authorities.
>
> Proposals to become Area Health Boards should clearly document how Mäori people have participated in the process of consultation and planning. The arrangements proposed to ensure that they will continue to be involved in the subsequent development and administration of the area health board should also be specified (Dept. of Health, 1987).

The National Interim Provider Board (NIPB) managed the structural changes of the 1991 health reforms. They were charged with overseeing the radical shift from a consultative to a competitive health model, and were mindful of the government's Treaty policies and obligations and reported as follows:

> The NIPB expects that the Crown's general Treaty of Waitangi policies will continue to apply to health sector assets and activities after the reforms.

> Although Area Health Boards are not part of the "legal" Crown, the Waitangi Tribunal can consider claims relating to acts or omissions by the Crown in respect of area health board assets or activities, and has done so. The process of transferring those assets to Crown Health Enterprises and Regional Health Authorities does not change any Treaty of Waitangi obligations the Crown may have and does not weaken the position of Mäori claimants as the assets remain in Crown-owned entities (NIPB, 1992, p58).

This recent momentum to incorporate the Treaty in all aspects of the health delivery and health management system dissipated in the 1990s. Several factors may account for this, including the ongoing fragmentation of the health system, engendered in the reforms of the 1990s and dominance of the commercial model in the health sector, and consequent lack of clarity over whose role it was to monitor Treaty compliance in health.

From the above it is clear here is a marked contrast between the specific Treaty policies of the1980s, with directions on how they can be implemented at the regional level, and the statements in the 1990s about the Treaty at the national level. The generalised position the government took at the national level in the 1990s appears to have placed no expectation that regional health services would comply with the Treaty and there has not been active monitoring to ensure that they did so. For example, the Green and White Paper "Your Health and the Public Health" (Upton, 1991), contained no reference to the Treaty whatsoever. The monitoring issue is discussed in some detail in a later chapter. The degree to which this was government naivety (perhaps in part due to the National Party's more distant links to traditional Mäori power structures) or oversight is difficult to determine. Certainly, the 1990 health sector reforms included a wish to lessen the effectiveness of, or capture by, interest groups in the health sector, and Mäori may have been perceived as one, if not one of major importance.

Treaty compliance and implementation at the regional level was left to the individual CHE to interpret. The proactive stance the Department took in the late 1980s dissipated with the drive to meet the commercial expectations of the new Government initiatives in the 1990s.

Many of the senior health service managers in Area Health Boards of the late 1980s were replaced in the 1991 reforms. In particular, the newly created commercially focused Crown Health Enterprises (CHEs) often employed a CEO with a commercial background, such as Auckland Healthcare, whose first CEO was Denis Pickup, an ex Brewery General Manager. The loss of institutional memory in the transition, plus the change in organisational culture and leadership, may also partially account for the reduced emphasis on the Treaty.

However, it is evident in much of the documentation reviewed for this study that the Treaty and interpretation and application of its articles in the health context was no longer driving government policy in the mid 1990s. For example the Minister of Health's Policy Guidelines for Mäori Health 1995/96 make the following references to the Treaty of Waitangi:

> Securing the place of the Treaty of Waitangi in the health and disability sector will be fundamental to the improvement of Mäori health in the medium term.
>
> The government has affirmed that the Treaty of Waitangi is New Zealand's founding document (Shipley, 1995, p10,19).

Aside from this affirmatory rhetoric, little is provided by way of explanation as to the nature of that place, or the means of operationalising the Treaty in the

planning and delivery of health services, in contrast to the detailed Department of Health advice to Area Health Boards (Dept of Health, 1987).

## Mäori Health as a Health Gain Priority

Concurrent with the restructuring of the health sector in the 1990s the Government identified Mäori health as one of its four health gain priority areas. This influenced government policy and objectives. The most comprehensive description of the Government's objectives for Mäori health at the start of the 1990s round of health sector reform is found in "Whaia te ora mo te iwi", a statement of response to Mäori issues in the health sector, published in 1992. The Minister of Health stated in the foreword that the Government " regards the Treaty of Waitangi as the founding document of New Zealand, and acknowledges that government must meet the health needs of Mäori and help address the improvements of their health status" (Dept. of Health, 1992).

In a separate document also titled Whaia te ora mo te Iwi(1993), a statement of Mäori health policy objectives for the Regional Health Authorities and the Public Health Commission, the government indicated how it would implement policy to achieve the Crown objective. In the attempt to meet Mäori needs, Regional Health Authorities were obliged to encourage providers to:

- be aware of and responsive to the aspirations and interests of Mäori;
- be aware of and responsive to the diversity of Mäori needs and expectations;
- encourage greater participation of Mäori in service provision and the delivery of culturally appropriate services;
- work sensitively with Mäori and Iwi through high quality consultation;

- recognise the tikanga and mana of each Iwi group in their region;
- consider how the health needs of Mäori who are outside their own rohe were to be met;
- be aware that Iwi and Mäori groups have their own vision of health, often linked to their history (Dept. of Health, Te Puni Kökiri, 1993).

The overall Government objective for Mäori health was to "seek to improve the health status of Mäori, so that in future Mäori will have the opportunity to enjoy the same level of health as non-Mäori" (Ferguson, 1998). The notion of partnership with Mäori, particularly at the level of Mäori political institutions is lacking. The Crown set out to remedy Mäori health status its way.

Mäori health has remained a high priority for government in its funding and delivery of health services. Policy advice to the incoming National/New Zealand First coalition government following the 1996 election stressed that the three key issues in Mäori health were:

- Mäori health remaining a health sector priority for improvement
- The need to consolidate gains in Mäori health development
- The need to continue to acknowledge the special relationship between Mäori and the Crown under the Treaty of Waitangi

because Mäori continue to lag behind non-Mäori in almost every indicator of health status (Steering Group, Ministers of Health, 1997).

## Monitoring the Treaty and Health

It has been difficult to establish who held the responsibility during the period 1990-2000 for monitoring of Crown Companies to ensure they met the government's objectives and did not breach the Treaty and honoured its

principles. The fragmentation of the public health services over that time is one factor that has led to this confusion. Earlier comments about accountability and the commercial interests of providers and funders apply in equal measure to the issue of monitoring.

It might be, as some of the interviewees in this research thought, that the monitoring of Hospital and Health Services (HHS) and their Treaty compliance was the responsibility of Te Puni Kökiri. This was not so. Te Puni Kökiri did not have a monitoring role at the local or regional level. Their focus was at the central decision-making level. The agency review process did not look at performance but was process focused. They were not involved in the monitoring of Hospital and Health Services.

> In the Ministry of Mäori Development Act 1991, Te Puni Kökiri is required to "monitor, and liaise with, each department and agency that provides or has a responsibility to provide services to, or for, Mäori for the purpose of ensuring the adequacy of those services". This has led the Monitoring and Evaluation Branch to focus on reviewing the policy advice, purchasing processes and decision-making processes in the public sector.
>
> CCMAU is responsible for monitoring HHS on behalf of the Crown, as owner of those companies (Davies, 1999).

Te Puni Kökiri was not the only Crown entity to believe that CCMAU held the monitoring role. The Mäori Health Commission also supported this definition of their role. The former Commissioner Wayne McLean stated that the opinion of the Commission was that the role of oversight and monitoring of the HHSs was the responsibility of CCMAU (Linkhorn, telephone interview, 1999).

However, it is not evident from the publications of the Crown Company Monitoring Advisory Unit that the monitoring of HHSs for Treaty compliance

came within their monitoring role. CCMAU published a booklet (1999) to clarify its roles and responsibilities. It contains no reference to the Treaty of Waitangi.

When the question was put to Crown Law to raise with CCMAU on the researcher's behalf, the Assistant Crown Counsel wrote:

> I am advised that no information is held by the Crown Company Monitoring Advisory Unit that specifically addresses your request for information on "how Crown companies are monitored to ensure the principles of the Treaty of Waitangi are upheld and the interests of the Mäori Treaty partner are protected" (Linkhorn, Letter, 1999).

What is more, it was the opinion of the Mäori Health Commissioner that as the Treaty was excluded from the Health and Disability Services Act 1993 there was no obligation on Crown agencies to comply with or adhere to Treaty principles (McLean, telephone interview, 1999). The Health and Disability Services Act was the legislation that created the new health entities and established the new structural framework for health service delivery in the 1990 reforms.

This of course sits very strangely with the previously referenced statement of Jenny Shipley when Minister of Health, who, in the foreword to "Whaia te ora mo te iwi - Strive for the good health of the people" (Dept. of Health, 1992), stated that the Government:

> regards the Treaty of Waitangi as the founding document of New Zealand, and acknowledges that government must meet the health needs of Mäori and help address the improvements of their health status.

## The Crown as Owner of Hospital and Health Services

The ownership relationship between the Crown and CHEs/HHSs sat with two Ministers, the Minister of Finance and the Minister of CHEs (until 1996) or Health (post 1996 National/New Zealand First coalition Government), and was

exercised through CCMAU. The Crown established its expectations of its commercial entities through annual statements of owner's expectations. These formed the matching half to the CHE/HHS annual statement of intent.

CCMAU described itself (Clarke, 1999, p11) as an independent unit administratively attached to the Treasury. The publications from CCMAU and Treasury indicate that their internal culture does not appear to take into account the people-based principles that underpin the Treaty. The focus is economic and financial analysis driven. Interviews with CCMAU personnel did not clarify the exact legal and organisational status of CCMAU.

Statements of owner's expectations of Crown Health Enterprises contain few references to Mäori, and Mäori health, all of a relatively marginal nature. For example, the March 1998 Statement requires Boards of CHEs:

> In disposing of surplus facilities, ... ensure that you comply with the surplus asset disposal requirements, including;
>
> the relevant protection mechanism which addresses the Crown's obligations under the Treaty of Waitangi, and good governance over Mäori sites of significance

This same document further notes that CHEs are also required by the Health and Disability Services Act (1993) to:

> assist in meeting the Crown's objectives under the Act, which include the special needs of Mäori for health and disability services.

The Mäori Health Commission developed policy with CCMAU (1999) to include Treaty-based obligations in the annual set of expectations. The 1999 Statement of

Expectations from the Shareholding Ministers refers for the first time to principal objectives and performance expectations of HHSs for Mäori health:

> Mäori Health
>
> Principal objective
>
> The Crown's overall objective for Mäori health is to improve Mäori health status so that Mäori have the opportunity to enjoy the same level of health as non-Mäori (CCMAU, 1999 – see Appendix 1).

This change appears to reflect the government policy changes bought about as a result of the 1996 National/ New Zealand First Government Coalition agreement, and specifically the advice to the government on implementing that policy, as referred to in previous chapters (Steering Group, Ministers of Health, 1997).

Interdepartmental work in 1997 and 1998 by Te Puni Kökiri in partnership with the Ministry of Health, Health Funding Authority, Mental Health Commission and Mäori Health Commission produced a matrix of critical success factors which "should be used as the basis for evaluation of funder and provider performance" (MHC, HFA, MOH, 1998). While the partners focused on the funding and delivery of mental health services, the document's principles are in many cases more generally applicable to Mäori health service delivery. For example, when evaluating a mainstream service provider such as Healthcare Hawke's Bay on the issue of Mäori access, the critical success factors are listed as:

> Can the provider demonstrate strategies are in place to ensure that access to the service is as easy and effective for Mäori as it is for non-Mäori?
> Does the provider check that Mäori know when and how to access services?
> Can the provider show that there are strategies in place to encourage Mäori to access services at early stages of their illness? (Mental Health Commission, 1998).

While the Crown has been much less explicit in the1990s in respect of its Treaty obligations and health, it is clear throughout the health sector that Mäori health and Mäori health disparity remains a major Crown concern. Numerous reports by Te Puni Kökiri, the Ministry of Health, the Health Funding Authority and independent health researchers confirm that fact (TPK, 1994, MOH, 1998, HFA, 1998, Pomare et al, 1995). If health and wellbeing are taonga, treasures protected by Article 2 of the Treaty, as both Professor Mason Durie and the Department of Health have held, (Durie, 1989) then clearly the Crown has failed to protect and enhance Mäori health to the same degree as that of other citizens.

The reduced focus on the centrality of the Treaty to health in policy, contract and law during and following the 1993 health sector reforms suggests a loss of focus on the Crown's responsibility for Mäori health in the specific light of the Treaty of Waitangi, during that period. Furthermore, it suggests a lack of commitment on the part of the Crown, to involve Mäori adequately in solution seeking. The Minister of Health, as quoted earlier stated that the Government " acknowledges that government must meet the health needs of Mäori and help address the improvements of their health status" (Dept. of Health, 1992). The Crown appears to act as if the problem of Mäori health status, and the solutions thereto, are its own singular concern, at the policy formation and funding allocation level. Mäori may participate as providers of solutions, but may not help determine what suitable solutions are to be.

The evidence reviewed in this chapter suggests that the Crown during the 1990s has clearly failed to set objectives and standards in respect of Crown agency

response to the Treaty of Waitangi, let alone monitor the performance of its CHEs in respect of Crown obligations under the Treaty. While the CHEs were commercial enterprises, the ownership interest in them was entirely the Crown's. If the National Interim Provider Board's view was correct, the Crown cannot release itself from its obligations to protect and promote the rights of Mäori by commercial constructions (see earlier discussion regarding the unitary Crown).

# CHAPTER 3 - HISTORICAL OVERVIEW OF NEW ZEALAND'S SOCIO-ECONOMIC REFORMS: 1938 - 1997

> Practical men, who believe themselves to be quite exempt from any intellectual influences, are usually the slaves of some defunct economist - John Maynard Keynes (Easton, 1997, p245-6).

The New Zealand health sector as it is today grew out of the establishment of the Welfare State in the 1930s. The post-1984 reforms to the Welfare State, based on burgeoning costs, a decline in the New Zealand economic performance in comparison with similar nations, and the introduction of "New Right" economic ideologies eventually, also came to dramatically change the face of the New Zealand health system.

This chapter provides some historic background to the New Zealand Welfare State, and its development. It then examines the radical transition in New Zealand society begun in 1984 as a result of the factors outlined above. The roles of ideology, the place of public versus private provision, are considered, along with the internationalisation of the New Zealand economy. This provides the necessary context to an understanding of the most recent changes within the New Zealand health sector. The following chapter commences with the impact of international influences on the New Zealand health sector, followed by a review of mainstream health sector changes in the 1980s and 1990s.

# The Establishment of the New Zealand Welfare State

The structural reforms of the 1980s were not the first example of New Zealand government ideology influencing, driving and shaping health policy. Walter Nash's 1936 Budget was a declaration on the nature of the social democratic state in New Zealand society and provided a blueprint for how that society would exist. According to Nash, the aim of the state was to:

> ... organise an internal economy that will distribute the production and services of the Dominion in a way that will guarantee to every person able and willing to work an income sufficient to provide him and his dependents with everything necessary to make a 'home' and 'home life' in the best sense of the meaning of those terms (McKinlay, 1987, p15).

In 1938 the first Labour government funded and directed the activities of what was intentionally a 'welfare state', in which the government took responsibility for the welfare of New Zealanders from the cradle to the grave. It established "a single scheme covering everyone for every need" (Mendlesohn, 1954, p184).

The legislation that imposed change on the health sector was the Social Security Act 1938. It is an example of revolutionary change in the health sector driven by the ideology of the prevailing government. The Act mandated an open-ended commitment to universal access to health care for all citizens and has been described as the world's first national health service (Cheyne, O'Brien & Belgrave, 1997; Rudd, 1997). The ideology promoted that access to health care was a social right and should be based on need not ability to pay. The extensive coverage in welfare benefits heralded what has been described as the 'golden age of the welfare state' (Rudd, 1997, p256).

The Act included provision for medical, hospital and other health related benefits, placed under the responsibility of the Minister of Health. Its intent was to legislate for universal access to a comprehensive health care system. Before 1938 and particularly before 1900, there was no single or coherent policy driver directing the funding or financing of health care in New Zealand, and many different arrangements could be found. Individuals paid for primary medical care on a fee-for-service basis, to the best of their ability, including a rudimentary medical insurance structure based on benevolent societies, unions, and the like, whereas local and central governments jointly financed hospital and related care. Public health responsibilities gradually evolved and centralised after the 1918 influenza epidemic (Bloom, 2000; Cheyne, O'Brien & Belgrave, 1997).

The Social Security Act (1938) provided public hospitals with a daily payment initially set at six shillings per bed-day. Although the sum was increased from time to time by government, it did not keep pace with the rising costs of hospital care. This resulted eventually in an unmanageable burden on local government and charitable organisations. It was evident by the 1950s that there was no option but to change the basis of hospital funding. The responsibility for all hospital funding was transferred to central government by 1957.

By the mid-1960s the NZ government was having difficulty financing the comprehensive provisions of the welfare state (Richards, 1994). Due to the public hospitals being entirely funded by central government at this time, the financial status of the patient and their ability to pay was immaterial. Admission was determined strictly by clinical need. There was a consequence for patients who

found it increasingly difficult to gain admission to a public hospital for elective surgery, and were denied admission altogether if the hospital determined that the need for surgery was not sufficiently urgent. This ad-hoc form of rationing predated the deliberate and transparent attempts via the 1990s health reforms to formalise rationing through core services and guidelines (Core Services Committee, 1994).

Expenditure on health services in New Zealand in the 1960s was high by international standards. In 1961/62 New Zealand's expenditure on health services as a percentage of national income was 6.5 per cent, only 0.3 per cent behind the USA in the same year and 0.5 per cent greater than Australia's expenditure in 1960/61 (Bloom, 2000). In the 1967 Budget the National Government introduced unique restraints on grants to hospital boards. They no longer were permitted to determine their own financial requirements and control was shifted to the Health Department (Bloom, 2000). Change was looming in the coming decade.

## 1970s -The Welfare State Under Pressure

The 1970s were marked by a number of crises that buffeted the New Zealand economy, such as the oil crisis, and Britain joining the EEC triggered New Zealand industry reviews and assessments. Identified problems were concerns about poor industry productivity, export market performance and input costs. The New Zealand economy was viewed as insulated, dependent and required 'fixing'(Britton, 1992; Easton, 1997; Jesson, 1999).

In this decade there were three particular innovative social welfare initiatives implemented that were reminiscent of the first Labour government's welfare

policies. In 1972 the Accident Compensation Act was enacted which introduced a no-fault, comprehensive system of compensation for all personal injury and death. Accident Compensation used creative means to fund the programme in comparison to existing social benefits. Compensation was to be earnings-related as opposed to a flat rate and financed largely by levies on motor vehicles and employers as opposed to general taxation.

The second significant development arose out of the recommendations of the Report of the Royal Commission of Inquiry into Social Security 1972. The Commission recommended the introduction of a statutory domestic purposes benefit, commonly known as the DPB, for sole parents, women caring for infirm and sick persons, and women alone. This welfare provision was innovative in that it recognised the statutory right of sole parents to income support, irrespective of fault. Previously a discretionary benefit had been available for sole mothers, provided they met the criteria which was that the 'male breadwinner' was absent through no fault of the intended beneficiary. The Domestic Purposes Benefit did not discriminate against unmarried women or women who left their husbands and sole fathers were also eligible.

The final major welfare reform of the 1970s addressed the provisions of pensions for the elderly. The complex dual system, Age Benefit and Universal Superannuation that did exist required examination, particularly after rapid inflation after 1970 reduced the real value of pensions. The Labour Government of 1972-1975 proposed an earnings-related scheme, financed by levies on earnings and by employers' contributions.

In 1975 the National opposition responded with a proposal for National Superannuation. Brian Easton (1997) has described this scheme as the 'most expensive' election bribe in the history of New Zealand. National Superannuation was to provide that all persons aged sixty or over would receive a flat rate benefit equal to 70 per cent of the average weekly wage; the benefit was inflation adjusted, and financed wholly by taxation. Additionally, National Superannuation was not subject to any income test. After the change from the Labour to National Government in 1975 and the introduction of the Scheme in 1977, government expenditure on pensions virtually doubled (Rudd, 1997).

These policy initiatives of the 1970s increased welfare coverage and gender equity. The irony was while the innovative developments in welfare provision were taking place New Zealand was entering a prolonged economic recession, with low economic growth, high inflation, increasing unemployment, and resulting in a growing public indebtedness (Easton, 1997; Rudd, 1997). While the post-war decades had seen stability in welfare policy coverage and expenditure the 1970s saw a dramatic rise in social welfare expenditure. The costs increased from 5.69 per cent of GDP in 1971/72 to over 11 per cent in 1980/81(Rudd, 1997).

By the late 1970s, the momentum for change had started to gather. New Zealand, once near the top of the OECD tables for economic performance and social welfare, had fallen well down the list. At the close of the decade the pressures were mounting to review and evaluate the welfare state. Some of the arguments of

the time suggested that the welfare state was considered to be undermining competitiveness on two counts. Firstly the level of taxation required to sustain the welfare state reduces commercial profitability, which increases the cost to the market and makes it uncompetitive. The second thrust of the argument was more overtly anti-welfare when it was argued that the safety net of welfare benefits caused workers to lose the incentive to work (Douglas, 1993; Pierson, 1991). Health service provision, too, would begin to change.

## 1980s - A Society in Transition

### A New Ideology

In the 1980s a new jargon swept New Zealand, the language of neo-liberal reform. Key phrases such as market economy, restructuring, competition, stakeholders, New Right, Business Roundtable, efficiency and rationality became common to explain the revolutionary change New Zealand society experienced.

> 'Neo-liberalism' describes a critique of political action based on a combination of classical liberal philosophy and present-day, market-oriented economic theory. From classical liberal philosophy and contemporary economic theory, neo-liberalism draws an emphasis on individual liberty, as both morally desirable and conducive to the well-being of society. From economic theory, it draws a scepticism about the capacity of activist government to improve upon the outcomes of voluntary exchanges. Neo-liberalism is, in essence, individualistic, pro-market, and anti-utopian in its vision of the state (Miller, 1997, p341).

Ironically it was the fourth Labour Government after its election in 1984 that initiated and implemented this major programme of neo-liberal economic and social reform. In the early 1980s the state was viewed critically by many New Zealanders. New Zealand was a highly regulated society and the state's role was that of regulator of economic and social processes.

> In the broadest terms Labour's agenda (post 1984) and that of its advisers from overseas and within New Zealand, opened the way for the elaboration of 'market forces', or more correctly, the regeneration of capitalism. Seen in its historical context, this 'development' strategy meant the institutional structures which had aided post-World War Two growth had to be dismantled. Labour's agenda involved several components: changes in macro economic management (a floating exchange rate, lower tariff barriers, less control of currency flows and interest rates, taxation reform), an overhaul of the social welfare system (health, education) and a changed management philosophy in the public service (Britton, 1992, p11).

Underpinning the ideology of the Labour government led New Right reform was the commitment to the market in preference to the state as the means of allocating resources, and an emphasis on greater individual and corporate freedom as the key to economic and social progress. In the casting about for solutions the decline in economic growth was blamed on the size of the public sector.

The 1984 Treasury briefing paper Economic Management presented to the incoming Labour government recommended three ways of assessing the future of state sector activities.

> Where the benefits of these were primarily individual and separately identifiable, they should be sold (privatised); where the benefits were both societal and individual, state owned enterprises should be established and expected to operate commercially (corporatised); and where the benefits were more societal than individual, government departments should remain, (departmentalised). Treasury argued that the departmental form of organisation was not conducive to the efficient production of goods and services for the market (Britton, 1992, p165).

The prescription that was proposed by the fourth Labour Government was of a reduced role of the state in the economy and a dramatic restructuring of the public sector. Underpinning the change was the strong belief that the government needed to separate its core functions from those public sector businesses that primarily

provided marketable goods and services. That prescription had been influenced by private sector interests in a way that was quite new.

## Private Sector Influences on the Government of 1984 and beyond

Reserve Bank Governor Don Brash stated in a 1996 Hayek Memorial Lecture in London:

> 'The economic debate brought together a small but strategically influential team of civil servants, think tankers, policy makers and politicians around Roger Douglas. This group of quite remarkable people understood clearly what needed to be done and was committed to seeing it through' (Jesson, 1999, p13).

The 'small but strategically influential team' clearly included Treasury and Reserve Bank officials advising Douglas, and a group of businessmen who became increasingly influential and constituted the inner circle of the Business Roundtable (BRT) from 1986: Alan Gibbs, Doug Myers, David Richwhite and Ron Trotter.

There was an informal link with Treasury and BRT and at times the advice or position of the two matched. The Chief Executive of the Business Roundtable from 1986 was Roger Kerr who was recruited from the Treasury think tank. After Kerr's appointment Easton describes the BRT as the most prominent private sector advocate of the commercialist approach (Easton, 1997).

The Business Roundtable was instituted in 1980 and took its name from the Business Roundtable in the United States. It had met informally from the mid-1970s. Its early industrial membership had been expanded to include chief executives from major investment and financial organisations. The Business

Roundtable has progressively taken public stands and challenged the government of the day on policy issues, including fiscal strategy, electricity pricing, Accident Compensation Corporation, tertiary education, public spending efficiency, labour market reform, replacement of export incentives and unemployed income support (Britton, 1992). The BRT supported privatisation and changes in arrangements for the delivery of health care and education, and industrial relations in a direction that could be readily described as favouring private enterprise.

The level of influence of the BRT extended beyond the private sector and a number of BRT company directors were advisers to government during state sector reform and later held directorships in SOEs, as Table 2 below illustrates.

## Table 2: Business Roundtable Company Director Links to State Owned Enterprises, 1989

| Business Roundtable Companies | | State Owned Enterprises |
|---|---|---|
| Fletcher Challenge | ------- | Telecom (privatised 1990) |
| Brierly Investments | | |
| Carter Holt Harvey | | |
| BNZ | ------- | Government Life |
| Lion Nathan | ------- | Electricorp |
| ANZ | | |
| Magnum | | |
| Quality Bakers (GFW) | ------- | Coalcorp |
| National Bank | | |
| AMP Society | ------- | Electricorp |
| Shell NZ Holding | | |
| Comalco | | |
| Newmans Group (Corporate Investments) | ------- | Airways |
| Wilson Neill | ------- | Government Property Services |
| Mainzeal | | |
| Steel and Tube | | |
| Union Shipping | | |
| Ceramco | ------- | Telecom (privatised 1990) |
| United Banking | | |
| Mconnell Dowell | | |

(Britton, 1992, p 52)

One of the most explicit examples of the pervasive influence of the BRT was that of Ron Trotter (knighted by Labour). He was chairman of the BRT, which was publicly advocating privatisation, and chairman of Fletcher Challenge, which at the same time was involved in buying a number of state assets (Easton, 1997). He also chaired the board of Telecom and the State Owned Enterprise Monitoring Group. Sir Ron Trotter was also a director of the Reserve Bank during the mid-1980s and later a chairman of the National Interim Provider Board which steered the 1990s National government initiated health reforms. This one example demonstrates the network of the BRT and ability it had to influence the Labour Government of the mid-late 1980s.

## The Fourth Labour Government 1984 - 1990

The most recent round of socio-economic reform in the 1990s, although initiated by National governments, has its origins in the Labour government initiatives of the 1980s when radical measures were introduced to reform the public sector. The Labour government based its rationale for public sector reform on it being essential to get a better return from state owned assets if the government was expected to meet the demands for lower deficits and taxes but provide increased support for those least able to help themselves. On 12 December 1985, Roger Douglas, the Minister of Finance, in an Economic Statement to the House of Representatives said:

> There is scope for improving efficiency within the public sector. This will increase our ability to reduce the Government deficit, lower taxes, and provide income support and social services for those least able to help themselves. In the case of trading operations inefficiency can represent a tax on their customers. The essence of the problem is that the public sector

> needs to be adapted to meet the management needs of the modern economy (Chew, 1989, p2).

Poor performance was attributed to the institutional framework in which public sector organisations operated. The flaws were identified as their lacking in clear objectives, competition, and performance incentives. The development of state owned enterprises (SOE) policy focused on these areas.

> Targeted activities were reviewed to separate out commercial and non-commercial objectives and functions. New structures were sought to give managers clearer objectives and incentives to increase returns, with commercial criteria being the basis of performance assessment (SSC, 1987). Barriers to competition were removed, for example, in the deregulation of posts and telecommunications. The State Owned Enterprises Act became law in 1986, authorising the formation of nine new SOEs. A number of others were subsequently established... The Act set out the principles under which the SOEs are to operate and established a regime for accountability (Britton, 1992, p166).

This theme was not unique to New Zealand. It was echoed internationally after the lead of the Thatcher government in Britain that had embarked on programmes of privatisation. World Bank and IMF influence coupled with changes in democratic systems or governments, had also led to the implementation of similar structural adjustment policies in countries such as Chile, Argentina, Peru, Turkey, and several of the transition economies of Central Europe (Brook Cowen, 1997, p346)

Initially the Labour government did not turn to privatisation; instead it chose corporatisation. This has been defined as a process of "restructuring of government owned trading enterprises from departmental form into a limited liability company with balance structures and performance criteria similar to private companies" (Chew, 1989, p2). The Labour government regarded corporatisation as a politically pragmatic strategy that would be more palatable to

the public in that it would not have the same negative connotations of privatisation.

One of the key architects of the reformed public sector, Roger Douglas, Minister of Finance in the 1984 fourth Labour Government, initially denied the structure was directed towards eventual privatisation and described the changes in terms of public expenditure control. Simulation of private sector ownership may not have been seen as necessarily a step on the path to such ownership. While the architects may have been unaware of the possibilities and implications Treasury was well aware of the step from corporatisation to privatisation. In their 1984 post-election briefing Treasury indicated they supported privatisation. Officials explained to sympathetic private sector audiences that corporatisation was a step to eventual privatisation. The international trends indicated that if this government did not complete the transition from corporatisation to privatisation then a subsequent government would.

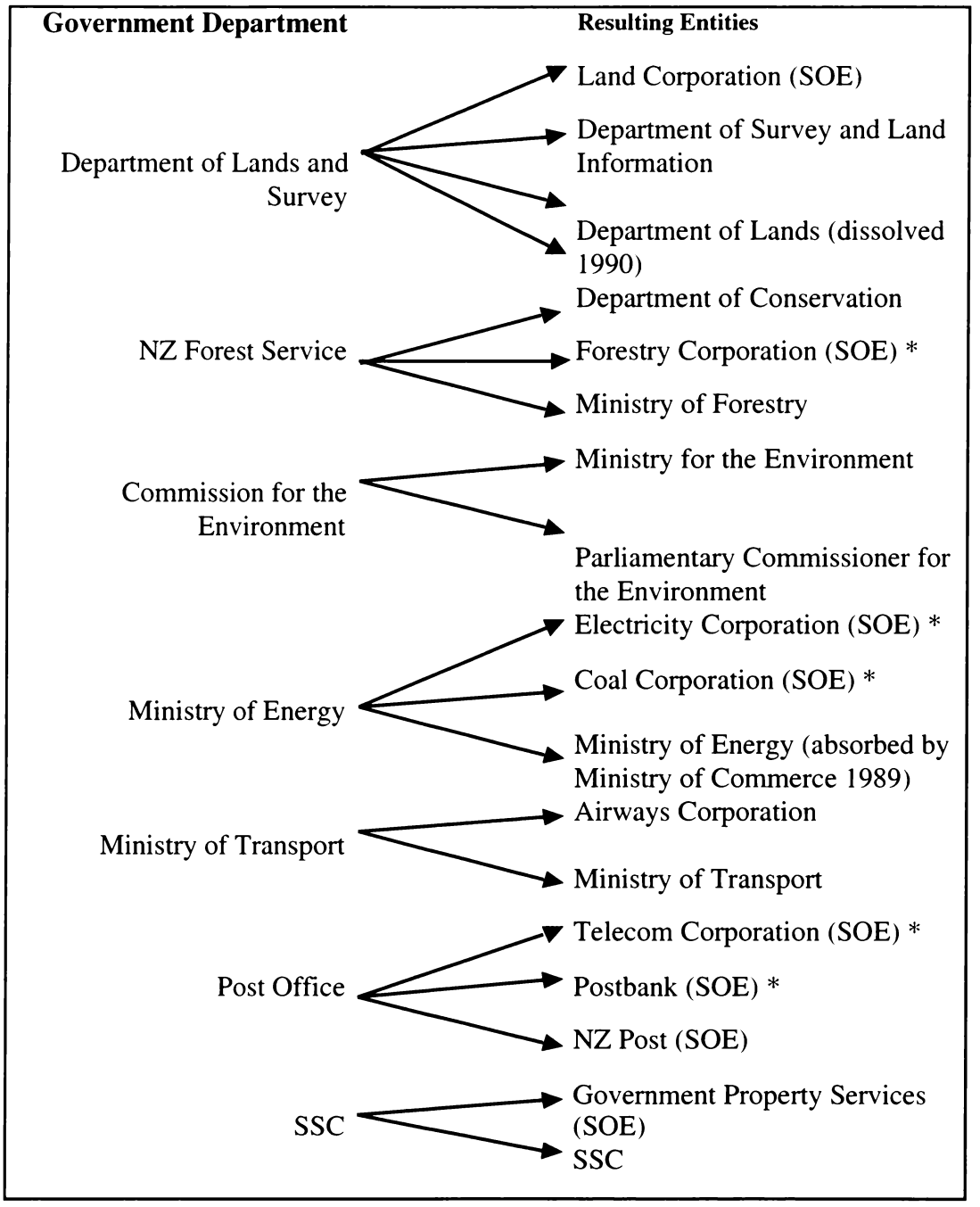
The State Owned Enterprises Act 1986 came into effect April 1987 and created nine SOEs (seeTable3) and provided the basic legal framework for their rights, obligations and functions. The SOE structure allowed the government to retain ownership of the trading enterprises and introduce the benefits of monitoring by financial markets to these organisations.

The SOE Act specified the objective of SOEs was 'to operate as a successful business'. The SOE programme affected over 60,000 employees. The corporatisation of the public sector was implemented with rapid speed and was

deliberately undertaken much more rapidly than in either the UK or Australia (Douglas, 1993).

The Economic Statement announced a set of principles for State Owned Enterprises (SOEs) that produced goods on a commercial basis. These principles were added to by the statement of Principles Guiding the 1986 Expenditure Review, which also put the trading activities of departments which were not SOEs on a more commercial basis, and the Statement on Government Expenditure Reform. None of the three statements is explicit about the form of ownership. The objective, corporatisation, was to mimic as closely as possible private sector ownership, with the shareholding being held by two ministers of the Crown. This created a structure that was ideal for privatisation.

**Table 3: Development of State Owned Enterprises (Britton, 1992, p166)**




* assets subsequently privatised

Although he had initially denied reform led to privatisation Roger Douglas later described the process of corporatisation of the public sector as 'polishing the

family silver' in preparation for sale (Douglas & Callen, 1987). The declared intention was the need to reduce public debt. The 1988 Budget statement spelt out the criteria for the sale of state assets. Douglas stated that 'the best approach to ridding the economy of deficits and debt is a combined programme of asset sales and a reduction in government expenditure' (Douglas, 1993, p33).

The December 1987 Economic Statement committed the government to a much more extensive form of privatisation, fully selling the state-owned enterprises that had been corporatised. Roger Douglas later argued that privatisation was the only answer due to cost savings and ultimately debt reduction (1993). Douglas believed that the market forces would improve the profitability of the newly privatised SOEs which they previously would not have achieved. The Douglas position was supported in the international forum by the World Bank who supported privatisation and in a 1992 study concluded:

> Private ownership makes a difference. Some state-owned enterprises have been efficient and well managed for some periods, but government ownership seldom permits sustained good performance for more than a few years. There is higher probability of efficient performance in private enterprise (Douglas, 1993, p35).

So corporatisation and privatisation proceeded, much as Treasury had envisaged, under Labour and under the following National government through the1990s. The official reason presented was that they were a means of getting down government debt, but in reality they were a part of the commercialisation strategy (Easton, 1997).

After Labour's re-election in 1987, the next wave of reform was driven by the desire for immediate fiscal savings. Treasury's briefing paper to the incoming

government in 1987 argued for implementation of greater clarity of objectives in management and the separation of operational activities from provision of policy advice, regulatory and funding activities. The first was the goal of the State Sector Act, 1988, which introduced private sector styles of management to the public service, with chief executives of departments being employed on five-year performance related contracts. The purpose was to improve the accountability, responsiveness and efficiency of the public service (Britton, 1992).

The second aspect of the Treasury paper was implemented by separating policy and service provision functions within departments. The consequence of this was a radically redefined public service. The rationale for the reform was to reduce the potential for policy advisers to be 'captured' by those delivering services, and to improve responsiveness to clients.

> By 1990, the 'new order' of the machinery of government could be summarised as consisting essentially of three central agencies (Department of the Prime Minister and Cabinet, the SSC and Treasury), ten mainly policy advisory agencies (usually called ministries, such as Defence, Education, Environment), 19 mainly delivery and transfer agencies (usually called departments, such as Conservation, Labour and Social Welfare) and two with taxing functions (Boston cited in Britton, 1992, p172).

## The Reform Process

Critical to how reform was achieved was the process. Fundamental to the success of implementing the reforms was the speed with which they were introduced. A rhetoric of crisis or doom regarding the sector was introduced, positioning the need for change. A policy goal would be announced which was radically different to the existing order, to be attained in a short period, following a surprise announcement and a very rapid implementation. Change was imposed rapidly

with the intention of preventing a concerted resistance from interest groups. The public's wishes could be discounted, for fear they could be manipulated by the pressure groups (Easton, 1997).

Roger Douglas has described his strategy in the following terms:

> If a solution makes sense in the medium term, go for it without qualification or hesitation. Nothing else delivers a result which will truly satisfy the public.
>
> Consensus among interest groups on quality decisions rarely, if ever, arises before they are made and implemented. It develops, after they are taken, as the decisions deliver satisfactory results to the public.
>
> Do not try to advance a step at a time. Define your objectives clearly and move towards them in quantum leaps.
>
> Vested interests continuously underestimate their own ability to adjust successfully in an environment where the government is rapidly removing privilege across a wide front.
>
> It is uncertainty, not speed, that endangers the success of structural reform programmes. Speed is an essential ingredient in keeping uncertainty down to the lowest possible level.
>
> Once the programme begins to be implemented, don't stop until you have completed it. The fire of opponents is much less accurate if they have to shoot at a rapidly moving target.
>
> The abolition of privilege is the essence of structural reform (Douglas, 1993, 215-238, in Easton, 1997, p80-81).

This type of approach does not allow the opportunity for reflection or alternative analysis. It also minimises the opportunity for public consultation if not prevents it completely. The Douglas approach generates a state of affairs that has been called 're-disorganisation' or a state of crisis that merits the need to restructure (Easton, 1997, p164).

Another key aspect to the strategy that Roger Douglas promoted was 'Replacing people who cannot or will not adapt to the new environment is pivotal' (Douglas, 1993). Effectively all critics or those that expressed a dissenting view would be removed. It raises the question of who protected the public interest when the reform process did not allow the opportunity to question whether the proposed policy solution was right.

At the heart of the strategy was a fundamental change to the nature of the democratic process and its operation (Easton, in Miller, 1997). Under the previous National Government (1975-84) the role of interest groups was recognised, and they were consulted and involved in government policy setting. The Labour government (1984-90) distrusted special interest groups and used a process of public consensus building to limit their influence (Kelsey, 1990). However, the vacuum in public input into government policy setting was not offset by other public participation processes, but by rapidly driven reforms, and hand-picked participants in public exercises such as the 1984 Economic Summit Conference. The influence of the party in power became paramount, at least between elections.

While the government pursued a policy of welfare benefit reduction the policies they chose to pursue (as in Great Britain during the Thatcher government) also increased the number of welfare recipients. For the period 1984/85 to 1990/91:

> the demand for social benefits increased considerably during this period, with the total number of people receiving benefits of some kind rising from 1,058,747 to 1,252,030. In particular, there was an almost threefold rise in the numbers of unemployment beneficiaries – clearly an 'overspill' from the fourth Labour government's economic policies. As a result, real expenditure per benefit recipient actually fell for a number of welfare benefits during the term of the fourth Labour government (Rudd, 1997, p261).

The Labour government 1987-1990 also cut some of the benefit rates and in some cases abolished them entirely, as in unemployment benefits for those aged under eighteen. Eligibility rules were changed with the intention of saving money. The age of entitlement to a state pension was to be gradually increased from sixty to sixty-five years. In March 1990 the Minister of Social Welfare was to claim that the fourth Labour government had cut benefits by at least $800 million a year, disingenuously, given the rise in the number of beneficiaries;

> ... with $150 million from changes to indexation, $300 million from the superannuation surcharge, $58 million from accommodation benefit changes, $25 million from benefit control units, $57 million from superannuation changes for those whose spouses did not qualify, $23 million from changes to youth unemployment, $7 million from school-leavers stand-down and $200 million from other measures.
>
> While the pursuit of reduction of welfare expenditure was used to justify a sweeping range of changes it reflected a short-term view of the effects of government policy. Changes in eligibility criteria may have a significant long-term accumulative impact, which would not be evident during the life span of a single term government. In changing the 'rules of the game' it can set the agenda for future governments, 'who inherit from their predecessors not just the policies themselves, but also the institutional structures and organisational procedures which shape the very policy-making process' (Rudd, 1997, p261).

The Treasury post-election briefing paper, Government Management (1987), explicitly laid down control of inflation as the overriding objective of government policy, and stated that any adverse effects on employment which resulted were unfortunate, but unavoidable. According to Treasury thinking, sound monetary policy would, in the long term, have no detrimental effect on employment.

> ... In its briefing, Treasury recognised the interconnectedness of monetary policy and the welfare state. The formal abandonment by the fourth Labour government, in 1987, of full employment as a primary government objective removed what had been, until then, the central feature of the New Zealand welfare state (Rudd, 1997, p261-262)

It is evident that major changes in economic policy have a relationship and influence on social policy (see Table 4). Changes in economic policy do not occur in a vacuum or isolation. The fourth Labour government 1984-1990 affected the development of the welfare state in two ways. Firstly, it refused to expand welfare provision in line with the increase in demand which arose from demographic changes and the consequences of its own policy. Secondly, it altered the 'rules of the game', or the political environment, in such a way that a long-term retrenchment of the welfare state was facilitated. The belief of the majority of New Zealanders of the right to access the safety net of the welfare system was profoundly shaken. Exposure to the new ideology had profoundly changed the shape of New Zealand society.

## Table 4: Main Policy Changes Since 1984

| Economy | State |
|---|---|
| Tariff reductions | Separation of policy formulation and service delivery |
| Floating exchange rate | New models of management and accountability in the public service |
| Removal of producer subsidies | Commercialisation of functions within government departments |
| Delicensing of industries | Corporatisation of state trading functions |
| Deregulation of monopoly/ protected activities | Privatisation of selected corporatised activities |
| Financial deregulation | Reform of local government and regional policy |
| Taxation reform | Targeting of social welfare payments |
| Labour market reform | Reform of environment administration and resource management law |
| | Strengthened role of Treaty of Waitangi and incorporation of Treaty of Waitangi in legislation |

(Britton, 1992, p12)

### Internationalisation of the economy

The changes experienced during the 1980s in the New Zealand economy did not occur in isolation as there were important ties between New Zealand restructuring and the global economy. Internationalisation, the deepening and changing links to the global economy describes several processes: the move to off-shore investment and production; the serving of local markets by production units owned or controlled by overseas based producers; the degree to which local economic activity is affected by global capital flows and production systems; and the extent to which domestic macro and micro-economic policy is shaped by external conditions (Britton, 1992).

The government's policy of deregulating the financial markets enabled money to circulate freely into and out of the nation. The effect of this placed the New Zealand business environment and its players into the orbit of the global

economy. The deregulated economy was attractive to foreign investors and from 1984 there was a dramatic rise in the level of foreign investment in New Zealand, as demonstrated in Table 5 below.

## Table 5: Trends in Foreign Investment in New Zealand

| March Years $m | Foreign Direct Investment in New Zealand | NZ Direct Investment Overseas | Non-resident Ownership of Public Debt |
|---|---|---|---|
| 1980 | 343 | 73 | |
| 1981 | 204 | 118 | |
| 1982 | 366 | 1115 | |
| 1983 | 364 | 604 | |
| 1984 | 205 | 54 | |
| 1985 | 456 | 349 | |
| 1986 | 745 | 166 | |
| 1987 | 402 | 949 | |
| 1988 | 238 | 938 | 40.8 |
| 1989 | 725 | 226 | 163.4 |
| 1990 | 1543 | 1477 | 400.0 |

(Britton, 1992, p28)

International influences were not limited to the economic marketplace. They also impacted on the broad market of ideas and nature and structure of the public sector in general. The next chapter (4) considers the influence of specific neo-liberal reform ideas in both Great Britain and the United States. Those influences also helped shape the scope and nature of the New Zealand public health sector reforms of both the late 1980s and 90s. The remainder of chapter four provides an historical overview of the New Zealand health sector reforms and focuses largely on the mainstream health sector structural reforms. The specific reform effects on Mäori will be outlined in chapter five which follows.

# CHAPTER 4: INTERNATIONAL INFLUENCES AND AN OVERVIEW OF NEW ZEALAND HEALTH REFORM: 1984-98

## International Influences

### Health Care Reform in the United Kingdom

> We have to sweep away myths, dispense with several sacred cows and conduct our discussions rationally ... outdated ideology must not be allowed to stand in the way. John Moore (1987)

The radical 1980s and 1990s reforms experienced in the New Zealand public sector in general and the health sector in particular were not confined to New Zealand. The same time period saw the United Kingdom experience similar restructuring of the welfare state with significant consequences for the health sector.

The United Kingdom National Health Service had experienced repeated attempts at its reform since the early 1960s. Successive governments had introduced changes aimed at making the service more efficient, or realistically cost effective. The Conservative government heralded changes in the health sector as part of their value-for-money policy in the early 1980s with the introduction of income generation schemes for the National Health Service' though these never produced the types of revenue return that advocates had predicted (Gladstone & Goldsmith, 1995).

At the same time, a policy of contracting out services became increasingly attractive to the government. By 1985 health authorities were required to put out their laundry, cleaning and catering services to competitive tender. These were the preliminary steps to the review of the NHS in 1988 by a confidential review team chaired by the Prime Minister that focused on the internal market model. The necessity for the funder/provider split was described as 'health authorities did not have an inalienable requirement to deliver services themselves but they were principally in existence to finance and manage the provision of services...' (Gladstone & Goldsmith, 1995, p73). In the autumn of 1988 the government decided that the ideas of self-governing hospitals and GP fund-holders as a route for the internal market would be the most successful basis for the reforms. These were striking similarities to the model being simultaneously proposed by findings of the 1988 Gibbs Report in New Zealand.

In January 1989 the British government White Paper, 'Working for Patients' was published accompanied by television campaigns and user friendly brochures. Central to the model proposed by the Conservative government was the internal market concept to separate the providers from the purchasers. The intention was to replace the centralised control system with a planned market model designed 'to expose providers to competitive tests of cost-effectiveness and quality while retaining safeguards for the consumer' (Gladstone & Goldsmith, 1995, p71).

Prime Minister Margaret Thatcher described the proposed reforms in her foreword to the government's White Paper 'Working for Patients' as

'represent(ing) the most far-reaching reform of the National Health Service in its 40-year history' (Gladstone & Goldsmith, 1995, p72).

The main proposals as stated in the White Paper were to secure two objectives.

1. To give patients, wherever they live, better health care and greater choice of services available.
2. To produce greater satisfaction and rewards for NHS staff who successfully respond to local needs and preferences (Gladstone & Goldsmith, 1995, p75).

The White Paper contained several key measures.

1. More delegation of responsibility to local level: responsibilities were delegated from region to district and from district to hospital.
2. Self-governing hospitals were formed. NHS hospital trusts were created by transferring hospital management and ownership to a trust with centrally and locally appointed directors.
3. New funding arrangements were created by making money follow the patients across administrative boundaries.
4. Additional consultant posts were created. Stricter control of consultant contracts was proposed.
5. GP practice budgets, later termed fund-holding practices, were introduced. GPs were able to use their fund to buy care from NHS providers or private practices on a cost-effective basis.
6. Management bodies were reformed by reducing regional, district and FPC size and by putting executive and non-executive directors on the authorities. An NHS management executive was set up.

7. Better audit arrangements were instituted. Medical (peer review) audit was made compulsory throughout the NHS; and the Audit Commission was asked to audit the financial accounts of the health authorities including the Family Health Service Authority and the NHS bodies.

The aim of the health sector reforms was to improve the efficiency in the production of services through the creation of a competitive market in the NHS in which the successful providers would expand and flourish. Consequently the boundaries between the public and private sectors of health care would blur. The next step was the belief that the health authorities would be free to measure and plan for the needs of their resident populations unhampered by the domination of self-interested providers. This underestimates the politics of health.

The UK reforms were greeted with a similar outcry to that in New Zealand. The common element in the opposition against the reforms was the feared outcome of introducing market principles into the health sector and the creeping privatisation. Similar to New Zealand, despite the opposition to the proposals, the Conservative government maintained its strong commitment to reform and adhered to a strict timetable for the introduction of change. With the general election that could be held at the latest in 1992 the political considerations meant that the reforms needed to indicate that they were successful before that time. There was considerable pressure on ministers to activate and implement the reforms expediently. The UK Conservative government was subsequently elected for a fourth consecutive term in the 1992 general election.

As in New Zealand there was no independent, non-governmental system established to monitor or evaluate the changes and outcomes of the reforms. Other factors complicate objective evaluation. After the 1992 election significant levels of additional funding were provided for the NHS. If there are recorded improvements in service provision and delivery it is difficult to ascertain whether they are attributable to extra resources or the introduction of the market model (Gladstone & Goldsmith, 1995).

In the post-reform NHS the district health authorities have the responsibility for assessing the health care needs of their population and commissioning the appropriate services for that population. The new responsibilities that the district health authorities are charged with are compromised by the budget restraints. There is a shortfall between matching the total needs of a population and resources 'a series of choices has to be made about which services are commissioned, in what quantities and for whom' (Gladstone & Goldsmith, 1995, p81).

Determining the priorities, a problem for the NHS prior to reform has been made more explicit post reform. It raises questions of, who should be involved in the determining of priorities on behalf of the population? How are priorities decided on and assessed?

The criticisms voiced in New Zealand over recent health reform were echoed in the United Kingdom. The over bureaucratisation of the reforms was symbolised by the growth in the numbers of NHS managers and the lack of public

consultation and consumer choice. Despite the rhetoric in the original proposal 'Working for Patients' that 'all the proposals ... put the needs of patients first' (HMSO, 1989 in Gladstone & Goldsmith, 1995, p82) consumers were not more empowered by the NHS reforms. Consumer involvement in critical decisions did not occur (Gladstone & Goldsmith, 1995).

The internal market model suggests that consumers can exercise influence in the health sector by their selection and utilisation of providers that deliver the services they want. 'Consumer choice would be based, not on government promise, but on that personal power to inflict economic pain on unsatisfactory producers which consumer payment alone can bring' (Gladstone & Goldsmith, 1995, p82). This is an unrealistic and confused argument given that the health services are nationalised and fully funded by taxes therefore consumers have already paid the full cost of the services they receive. As consumers have already surrendered their potential buying power to the government via taxation they have also surrendered their ability and freedom to choose. If supply of primary health services exceeded demand, the situation might well be different.

The reforms in the United Kingdom illustrate that as in New Zealand 'decisions about health care continue to be value-laden and to be inescapably set within an ideological and political context. In that and many other respects the post-1991 NHS has remarkable similarities to what preceded it' (Gladstone & Goldsmith, 1995, p82-83). The revolutionary reforms promised to deliver increased efficiency and more health care for the dollar. For consumers discernible benefits that

justified the upheaval are not easily evident or identifiable (Gladstone & Goldsmith, 1995).

## The Oregon Experiment

In the early 1990s the reforms proposed in the US State of Oregon attracted the interest of the New Zealand National government. Oregon was grappling with the issues of access, funding and prioritisation of the health sector. The State had recognised that sizeable numbers of its citizens did not have or qualify for medical insurance. The experience of Oregon was a microcosm of the dilemma facing the United States with over 37 million Americans uninsured (Brannigan, 1995).

In 1989, an estimated 400,000 Oregonians were uninsured, of these 120,000 were unemployed, while the other 280,000 although in working households, did not qualify for Medicaid, the public assistance programme for the poor. Eligibility for Medicaid is determined by each state, and Oregon had set its requirement at 58 per cent below the federal poverty level. The federal poverty level for a single adult is an annual income of US$6620; for a family of four, it is US$12 000. In Oregon, if a family made over US$6960 per year, it became ineligible for public funding (Brannigan, 1995).

There were other issues that complicated the Medicaid dilemma. The imbalance of funding within the programme particularly impacted on children. In 1988, although 70 per cent of the nation's Medicaid population were children, they acquired only 12 per cent of its funds. Eligibility of some of the specific programmes within Medicaid for impoverished families continued to decrease

which adversely affected many children and single parents. Oregon took steps to tackle the looming crisis in the health sector directly.

Issues of allocation were a major concern at the 1982 conference held by the Governor on Health Care for the Medically Poor, and the Oregon Health Council established Oregon Health Decisions Inc (OHD). The objective of OHD was to stimulate public awareness of issues in bioethics, particularly in health care apportionment.

OHD volunteers worked proactively during 1983 and 1984 holding 300 meetings throughout the state, involving over 500 Oregon citizens. In October 1984 the Citizens' Health Care Parliament concluded with a report, Society Must Decide, which reported the consensus was that 'Health care rationing, cost containment, and health resource allocation were seen, first and foremost, as community matters' (Brannigan, 1995, p29). This view presented health care as owned and defined by the community.

Two further health care parliaments stimulated further public discussions and recommendations for a more just health care system. A former physician, later politician, Senator John Kitzhaber, advocated universal access and fair distribution of health services in the state. Kitzhaber, OHD and others established the 'Oregon Medicaid Priority-Setting Project' (MPP). This endeavour concentrated on the principal groups of Medicaid beneficiaries, obstetrics and gynaecology, paediatrics, adult and geriatric and ranked a variety of health care benefits from some general health service areas.

The legislature also established an 11-member Health Services Commission (HSC), who had two goals: expand Medicaid coverage and establish a list of prioritised health care services, to be periodically reviewed. The process was to be that prioritisation recommendations would be made by the HSC to the legislature. If accepted, the state legislature which meets for six months every two years would then determine the level of funding and range of services for the next two year session.

This was a unique way to prioritise services. Historically shrinking health care budgets were reconciled by either lowering Medicaid eligibility, reducing access to health services, or by discounting reimbursements to providers. The approach of Oregon was to address its reducing health care budget by cutting those services that are lowest in priority. The cut-off line defining the range of services would shift according to legislative determination of the state's financial health.

### *The Oregon Basic Health Services Act of 1989*

The Oregon Basic Health Services Act (OBHSA) was passed in the Oregon Senate in 1989 with support in both houses. The fundamental principle of the OBHSA was that all citizens have a right to basic health care, that 'floor beneath which no person should fall' (Brannigan, 1995, p31).

The Act comprised three separate bills that were interrelated. Senate Bill (SB) 27, the Basic Health Benefits Act, sought to extend Medicaid coverage to all uninsured Oregonians below the federal poverty level.

> While extending coverage, a prioritised list of services is determined by the Health Services Commission. This list ranks condition/treatment pairs

> according to the net benefit of each, incorporating medical effectiveness and community values. This ranking assists the legislature's designation of the funding level, which will in turn demarcate a basic health care package for all citizens of Oregon (Brannigan, 1995, p30).

SB 534, the State Health Risk Pool, intended to provide health care to those who were classified as uninsurable due to 'pre-existing medical conditions'. The state and private insurers were to contribute to this 'risk pool', calculated to affect around 20, 000 people (Brannigan, 1995).

SB 935, the Health Insurance Partnership Act, required employers to offer the basic health benefit package from Senate Bill 27 to all full-time workers and their families. Employers and employees shared in the costs, employers contributing 75 per cent and employees 25 per cent, with increased employee contributions for optional dependant coverage. Incentives to employers by way of tax credits were offered if the scheme was implemented before 1994. This proposal was estimated to affect around two-thirds of the uninsured in Oregon (Brannigan, 1995). Casual and part time workers were still at some risk of being unable to access health services.

The Health Services Commission's model for the prioritisation of health services combined empirical data of medical effectiveness with community values. There was no comparable model with what Oregon was attempting to achieve. The HSC resourced an extensive campaign to evaluate responses and concerns about health care values from the community. This consisted of public hearings, community meetings and random telephone surveys.

The Clinton Administration on March 1993 finally approved the Oregon plan. Oregon's strategy tackles a monumental challenge: how is it possible to expand access to quality health care and still manage to control health care spending?

A consequence of a market-driven health care system is that it turns out to be ultimately profit-conscious, with services evaluated primarily in terms of their investment return, rather than on health care needs. And problems spiral since we tend to confuse 'health care needs' with 'health related desires'.

Oregon's experiment forces us to face squarely inequities within the current system. Its unique response to its finite budget is not to cut eligibility, or to diminish reimbursements, but to reduce spending for treatments which are considered to be of lowest priority, while access is guaranteed for all.

## New Zealand's Health System before Reform – local control of service provision

The health system as developed by the Labour government in the 1930s was accepted by New Zealand society. This was evident in the minimal difference in the health policies and funding among the major political parties for several decades. Evolving from the 1938 Social Security Act, the funding of health services, and particularly of New Zealand's major hospital infrastructure, was based on spending by 28 regional Hospital Boards supported by Government allocation from general taxation. Hospital Boards consisted of locally elected

representatives, who administered a structure usually managed by a Medical Superintendent, Chief Nurse, and possibly a Chief Executive or Administrator.

Hospital Boards were responsible for the delivery of three types of health services, general, obstetric, and mental services. Their funding was based on the comparative utilisation of inpatient services in each of the categories, though they were also responsible for the delivery of outpatient services. Service delivery and funding was largely weighted towards hospitals, and treatment services.

Hospital Boards were highly locally accountable, with a three-year Board election cycle on the same timeframe as other local body elections. However, funding accountability was diffuse, with central government footing the bill, but the local need and local interest groups driving the demand.

The first attempt at reform after 1938 occurred in 1974, when the second Labour government developed a policy that would have provided a system similar to that of the United Kingdom's National Health Service. The proposed change was driven by a desire for integrated service delivery across primary, secondary, and public health sectors, a precursor of the 1980s Area Health Board model. In addition the changes challenged GPs uncapped fee for service income and the particular interests of other health sector groups out of a need to contain costs, despite the attempt for financial control a decade earlier by the National government (Davis & Ashton, 2000; Davis & Dew, 1999).

The Third Labour Government's White Paper "A Health Service for New Zealand" (McGuigan, 1975) proposed a design for health administration aimed at improving efficiency and effectiveness in the delivery of care. The model proposed is described as the early forerunner of the Area Health Board model (AHB). Policy would be set at the central agency level and implemented in a way that would be reflected at the regional level, in hospitals and in general practice.

The medical profession and local politicians opposed the proposed changes and before they could be introduced the Labour Government was defeated at the 1975 General Election. The AHB model was to take another decade before it was formally introduced and even then it was done cautiously with the stipulation that local communities must support it.

By the end of the first Muldoon National administration (1978), a number of government reviews had questioned the sustainability of universal health provision, and ways to reduce the welfare burden on the state (Davis & Dew 1999). To solve its growing fiscal crisis, the state had to curtail government expenditure, over 50 per cent of which was in welfare, health and education (Rudd, 1997).

Between 1970 and 1980 health spending had increased from 5.1 per cent to 7.2 per cent of GDP, and was now falling behind the rapidly increasing spending in the United States, Canada, and Australia. In spite of the escalating cost, access to primary care was becoming restricted as a result of a decrease in the real value of the General Medical Services benefit from around 75 per cent of the total fee to

less than 20 per cent (Ashton, 1994). As a result fully funded hospital services were used increasingly by some members of the public as their only accessible primary health care. Consequently, issues of equity and cost containment dominated the health policy agenda in the early 1980s. This resulted in the introduction of a population-based funding formula for hospital boards, which will be discussed more fully below.

## Cost Containment

Population based funding for hospital boards was formally introduced under the National Government on 1 April 1983. The formula was developed by the Advisory Committee on Hospital Board Funding (Dept. of Health, 1984) after the then Minister of Health, George Gair, in 1979 requested the committee carry out an extensive and thorough review of the methods of allocating of funds to boards. The committee recommended a population based funding system after reviewing the funding arrangements of other countries.

The population based funding system the Committee recommended for New Zealand was similar in principle to those that had been adopted in Scotland and England. Some of the unique and unwieldy differences for New Zealand were the size of the hospital boards ranging in population from approximately 2,500 to over 800,000 at the time. Essentially the size of the board populations determined the size of equitable allocations.

The actual formula for funding calculated the boards' entitlements to funds using an assessment of their relative needs (see Formula p112). The resulting 'equitable

allocations' had two components, a population grant and a set of supplements. The population grant was designed to meet needs that were related to the populations served by boards. Although the allocation of the grant was based on population numbers, other factors such as the movement of patients between board districts was taken into account. The supplements were based on funds required for purposes not related to populations such as training of staff, or the transfer of patients to neighbouring boards who had higher level specialist services. The training of medical students was concentrated in a few boards, not spread across boards according to the numbers of trainees in boards.

### *How The Distribution Of The Population Grant was to be Determined*

Stage 1. Determine the total funds available for distribution.

Stage 2. Calculate each board's supplements.

Stage 3. Calculate the population grant by subtracting all the supplements from the total funds available.

Stage 4. Calculate each board's share of the population grant.

Stage 5. Calculate each board's equitable allocation by adding its share of the population grant to its supplements.

*Outline of the Formula*

Step 1. Determine board populations by age and sex.

Step 2. Calculate expected bed-days for each board and each age and sex for three types of service: general, obstetric, and mental.

Step 3. Apply cost weights to get bed-day-equivalents (BDE's).

Step 4. Adjust for differential mortality and fertility.

Step 5. Adjust for inter-board flows.

Step 6. Adjust for flows to the private sector.

Step 7. Divide grant in proportion to each board's BDE's.

(Dept. of Health, 1984).

The calculation of each board's share of the population grant, Stage 4, is the main part of the formula in the sense that it deals with the distribution of most of the funds.

### *Calculating Each Board's Share of the Population Grant*

The simplest way to allocate this grant would be in proportion to the crude population of each board's district. The Advisory Committee viewed this as unsatisfactory because of a number of factors:

- the need for health care varies greatly between age and sex groups, and board populations have differing age and sex structures
- environmental, ethnic and social factors may lead to differing levels of morbidity between board populations
- certain specialised care cannot be economically provided by every board – not only would this be costly but in some instances it would result in specialist units with low patient throughputs and poor quality care; it is therefore reasonable for patients to travel to boards offering specialist services and this needs to be taken account of in the funding
- in some board districts the private sector treats a higher proportion of patients; this relieves these boards of some responsibility for health care and to maintain equity their needs for public funding should be assessed lower.

The Advisory Committee acknowledged that the funding formula would involve value judgements about what is equitable.

It is perhaps helpful to make it clear that the Committee's judgements on equity were tempered by considerations of efficiency. It would have been more equitable for all boards, irrespective of size, to mount a full range of services rather than to have had some specialised services provided only within the larger boards. However, for all boards to mount all services would have been inefficient (Dept. of Health, 1984).

The introduction of the population-based funding formula for the allocation of resources to hospital boards was significant in New Zealand health policy as it

signalled an end to the open-ended policy that had existed since 1938. The implementation of the formula highlighted the tension between containing costs and continuing to provide the delivery of services that the New Zealand public had come to expect. The pragmatic rationing by health professionals at the individual level that had already been part of services now was to become both more overt and transparent.

Considerations of equity in the report clearly did not extend to Mäori. There is not one reference to Mäori in the Department of Health publication The Hospital Board Funding Formula 1984. The distinctive health needs of Mäori and associated cost for health provision to high-density Mäori populations was not factored in the formula. Mäori were accorded status neither on the basis of Treaty of Waitangi requirements nor on that of their poor comparative health status. The obligation of the Crown to ensure Mäori citizens received consideration no less than that of their fellows appears to have been completely overlooked.

## New Zealand Health Sector Restructuring

In New Zealand too, just as in Oregon, solutions had to be explored to grapple with the issue of cost containment in the health sector and prevent inequitable funding. Pilot studies aimed at rationalising the delivery of publicly funded health care were undertaken in Northland and Wellington in the late 1970s and early 1980s. In 1983 the Area Health Board Act was enacted. A major provision of the Act was the decentralisation of public health activities away from the Department of Health to regional agencies. Due to the National government's policy that Area

Health Boards (AHBs) would only be established on local initiative, progress on implementation was negligible during their time (1981-1984) in office.

Following the election of the 1984 Labour Government, health reform became but one strand of the sweeping economic and social reforms introduced at this time. The irony should be noted here that it was government workers being made redundant that primarily drove the dramatic increase in unemployment over the late 1980s. While promoting an ideology that loss of incentive to work was a consequence of the welfare state, the same state was withdrawing the opportunity to work from large numbers of workers. The growing popularity of these types of market ideology argument set the scene for the radical health reforms of the fourth Labour government in the 1980s(Ashton, 1995;Tenbensel & Gauld, 2001).

The continuing health sector problems in the 1980s, lengthening waiting lists, the inequitable distribution of health care services and perceptions of inefficient management, led to two major reviews of health services, both commissioned by the 1984 – 1990 Labour Governments. The first was the Health Benefits Review commissioned by the Labour Government in 1986 to 'report upon the underlying rationale for state involvement in health and to recommend broad principles and directions for reform' (Scott et al, 1986, p124). Five options were presented, the preferred option of the Review was a system that boards would 'establish rational priorities and plans by researching needs, discussions at the local community level and negotiations with a range of private, voluntary and public providers' (Scott et al, 1986, p125). The process was to determine the range of services required:

boards could put them out for tender and award contracts for services on the basis of quality and price.

The second review was conducted by the Hospital and Related Services Taskforce in 1988 and its report was commonly referred to as the Gibbs Report. Although commissioned and rejected by the Labour Government, the Gibbs Report, along with the Business Roundtable commissioned report from CS First Boston by Professor Patricia Danzon (Danzon & Begg, 1991) 'Options for Health Care in New Zealand,' provided the basis on which the 1990 National Government reformed the health sector in 1991. It is considered in detail later in this chapter.

Despite the rejection of the Gibbs Report recommendations by the Labour Government there were other major changes in health policy in the late 1980s. Hospital board management shifted from the old triumvirate system of nurse, doctor and administrator to the model of general management. To improve access to primary care the General Medical Services benefits were increased and general practitioners were given the option of joining a contract scheme which gave them an inflation-adjusted subsidy for all consultations in return for limits on user charges.

There were two phases of hospital sector restructuring that span both Labour and National governments of the 1980s and 1990s. These were successive attempts to deal with health sector structural weaknesses perceived by both political parties. The strategies were different. While Labour had introduced AHBs with increased managerial accountability, it had rejected the Gibbs "more market" approach.

The core of the health sector reforms of the 1984/1990 Labour government was the New Zealand Health Charter (Clark, 1989) that defined a set of goals for the public health system until the year 2000. This was instigated by the New Zealand commitment to the Alma Ata Declaration of 1978 (WHO, 1978). The goals of the Health Charter were to provide priority guidelines for the first time in New Zealand for the equitable allocation of health resources, and establish as a national goal the achievement of a substantial improvement in health outcomes. New contract requirements for Area Health Boards emphasising the performance and accountability of each Board to the Minister were released at the same time. The New Zealand Health Goals were identified as:

- To reduce the onset of smoking in non-smokers, especially adolescents, and to reduce the number of smokers and the consumption of tobacco.
- To reduce the incidence of dietary related health disorders by improving nutrition.
- To reduce alcohol-related health problems by reducing alcohol consumption.
- To reduce the prevalence of high blood pressure.
- To reduce preventable death and disability from motor vehicle crashes.
- To reduce hearing loss in children in the under five year age group.
- To reduce disability and death from asthma.
- To reduce avoidable illness and death from coronary heart disease and stroke.
- To reduce the incidence of invasive cervical cancer and the cervical cancer death rate.
- To reduce skin cancer (melanoma) incidence and death rates (Clark, 1989, p6).

These priority health goals addressed significant causes of death, disease or chronic disability. If attained it was believed they would reduce social and ethnic

inequalities in health status. To achieve the specific improvements of each goal measurable targets were set that were identified as medically attainable, required equitable resources, and were measurable as desired health outcomes. The Health Charter recognised the connection between health status and cost of provision of health care.

The stated objective of the Health Charter was to maintain a nationwide publicly funded health system with the overall goal of protecting and improving the health of all New Zealanders. Health care described as essential was to be universally accessible, 'in a manner that is acceptable to both individuals and the community, taking into account the cost that the community and the country can afford' (Clark, 1989, p1).

The development and operation of the public health sector was to be based on the New Zealand Health Charter principles with the stated expectation that health care managers and providers were expected to observe and follow the principles including;

- Respect for Individual Dignity
- Equity of Access
- Community Involvement
- Disease Prevention and Health Promotion
- Effective Resource Use

To achieve the desired outcomes of the New Zealand Health Goals the Government had to restructure the health sector to enable it to operate and implement the health care principles, in particular, the aligning of hospital and

public health services (Ashton, 1995). The previous split between hospital board and central agency (Department of Health) responsibility had to be corrected.

The new structure allocated specific responsibilities at three levels, Minister of Health, Department of Health and Area Health Boards. At the Ministerial level the Government accepted responsibility for setting national health policy and for funding public health. It was to be ultimately accountable for the quality and appropriateness of healthcare provided, and for the health status outcomes achieved. The Minister of Health was in turn accountable to Parliament that health services were provided and delivered in the most efficient and effective way. Accountability also extended to the effective implementation of the overall health policy.

The Department of Health had a direct reporting relationship to the Minister of Health and was to provide the Minister with strategic advice and analysis on health issues. It had a key role in overseeing the implementation of the Health Charter and reporting to the Minister of Health on that. The Department of Health was responsible for administering health legislation, regulations and the funding of health programmes and ensure the provision of health services. The Area Health Boards were to be the implementation arm of the governments' Health strategy, understanding local health needs, and developing and delivering services to meet those.

## Area Health Boards

After 1984, it was the Labour government that escalated the development of area health boards as it fitted with their model of accountability and fiscal control, and the government's need to have greater fiscal certainty in the provision of health services. While the rationing of health services has always been present in part, asset run-downs and the increasing cost of new technology in health (health inflation) led to a desire for more central control of funding risks inherent in the AHB structure (Bloom, 2000).

Area Health Boards had a statutory obligation to establish and maintain an appropriate balance in the provision and use of resources for health protection, promotion, education and treatment services. This represented a broadened construction of health and health services to include population health alongside personal health care. New contract requirements for Area Health Boards emphasising the performance and accountability of each Board to the Minister were released at the same time.

The Area Health Boards Act (1983) stated that the main objectives of an Area Health Board were:

- to promote, protect and conserve the public health and to provide health services within their region;
- to provide for the effective coordination of the planning, provision and evaluation of health services between the public, private and voluntary sectors within their area;
- to establish and maintain an appropriate balance in the provision and use of resources between health protection, health promotion, health education and treatment services (Nelson Health Services Advisory Committee, 1985, p15).

Area Health Boards were to ensure that public health expectations within their regions were assessed and met. This included providing and funding health care services from both the public and private sector.

A critical difference between Area Health Boards and their predecessor the Hospital Boards was the multiple accountabilities Area Health Boards were charged with. The Boards were accountable to the Minister of Health for implementing the New Zealand Health Charter and the effective and efficient use of public health resources.

They were also accountable to their communities through Community Health Committees and other consultative bodies. The communities that the Area Health Boards represented were able to exercise the option of democratically electing Board members at the local body elections. This provided an important opportunity for the community to participate at the regional level in the governance, management and provision of local health services.

The transition to Area Health Boards was not a sudden one however. Two geographical locations, Northland and Nelson, were selected as trial Area Health Boards in 1984. Following the apparent success of the model, other groupings of Hospital Boards moved slowly to Area Health Board status. Requirements for change included community support, and the process involved a considerable degree of consultation, as local communities came together to join their health services.

In 1989 the last of the Hospital Boards were disestablished and the elected Area Health Boards replaced them. Government appointments were added to Area Health Boards to supplement the locally elected representatives. With the passage of the Public Finance Act in 1989, Area Health Boards entered a contractual relationship with the Minister of Health, and the desired financial accountability regime was established.

The intention was that the Minister and each Board would conclude a contract before Government funding would be made available. Appended to the contract and forming part of it would be a five-year strategic plan and an operating plan. Each Board and the way they managed their funding would be subjected to unprecedented scrutiny. Future funding could potentially be at risk. It was a level of accountability to the Minister that had not previously existed.

However, before this system had a chance to demonstrate its effectiveness, Crown Health Enterprises were to take the place of Area Health Boards, operating under a different philosophy and model. They were part of the second and more radical wave of health reforms of the early 1990s initiated by the incoming National 1990 government.

## 1990s – Health in the Marketplace

November 1990 brought a change of Government. The new National Government quickly made it evident that the ideology of market principles (introduced for trading arms of the Crown such as Forestry by the previous government) would dominate all government agencies and further reform of the services the government traditionally provided would take place.

The Budget message of the new National Government 1990 made it clear that moves towards a competitive, market-oriented system would be paramount for the future development of New Zealand society. This fourth National government introduced a piece of legislation that effectively 'locked in' a policy framework designed to restrict future government flexibility with regard to welfare and government expenditure. The 1994 Fiscal Responsibility Act lays down various principles for a fiscally responsible government to observe. Included in the principles are the reduction of public debt to a 'prudent' level and the maintenance of a 'prudent' level of public debt, by achieving budget surpluses. Governments should also pursue policies which 'provide a reasonable predictability about the level and stability of tax rates' (Rudd, 1997, p265).

The implications were crucially significant. A government wishing to increase expenditure on any item that could include health, education or welfare by using previous budget surpluses, increasing the public debt, or raising taxes, would now have to repeal the Fiscal Responsibility Act or justify the departure from the principles of fiscal responsibility and state when and how a return to those principles would take place.

## National Government: 1990–93 1993-96

In 1991 the new National Government announced that the health sector was to be reformed again. There was to be no opportunity for analysis or review of the effects of the Labour Government's recently fully established AHB initiatives. The Green and White Paper "Your Health and the Public Health" (Upton, 1991) introduced a restructuring of the public health system that mirrored the

recommendations of the 1988 Hospital and Related Services Taskforce Report (the "Gibbs Report") rejected by the then Labour Government. It provided the blueprint for the radical reform the incoming National Government wished to implement. Central to the reforms was a shift from universal access on the basis of need to a targeting of health services to specific users, part charges for hospital inpatient and out patient care, and creation of a category of core health services that the government would continue to fund.

The Gibbs report was in two parts. The American accounting firm Arthur Andersen had purported to find potential efficiency improvements of around 30 per cent in the New Zealand health sector. However, it was later argued that 'much of its claimed potential 'productivity' amounted to cost shifting; that is, switching costs from the public sector to the individual patient, family, and community' (Easton, 1997, p152). Nevertheless the commissioning committee used the Arthur Andersen findings to support a management model that would achieve the presumed efficiency outcomes.

The 1988 Gibbs Taskforce Report entitled "Unshackling the Hospitals" had recommended that six Regional Health Authorities (RHAs) be responsible for determining and funding regional health needs. In turn those needs should be met by public, private, or voluntary agencies whose services would be contracted by each RHA on the basis of quality and value for money.

> Under our proposal area health boards would become more like the boards of public companies. They would be able to concentrate on running efficient services, helped greatly by the payment system which would give them an objective value of the services they provide. These prices would drive signals through the system, causing rapid improvements in resource use and clinical practice (Gibbs et al, 1988, p28).

A significant feature of the Gibbs Report was the recommendation that there be a separation of the funder and provider roles, as the RHAs would purchase health services from providers on behalf of the people in their regions. 'They would not manage or own any services but would contract with public, private and voluntary providers on a competitively neutral basis' (Gibbs et al, 1988, p27). Effectively providers were to be paid only for services provided and outputs met rather than for reimbursement of costs. This model was to be incorporated as the core of the 1991 Regional Health Authority reform programme.

The separation of these funder/provider roles was rationalised by the belief that hospital boards were biased toward their own institutions and services over private providers and community based care. Thus, it was argued that there was no control over inefficiencies or incentives when the same agency controlled services and their funding. However, the separation of roles appears ideological, as essentially the actual separation had previously existed with the Department of Health funding and allocating resources and the hospital boards providing services.

Diagnosis-related groups (DRGs) were considered to be the appropriate device for determining payment levels. DRGs would be paid prospective fees based on average rates for treatment of a disease or illness and would replace retrospective reimbursement of costs. The strong competitive element in the Taskforce recommendations fitted with the market ideology of the National Government of 1991 and it was that government that implemented the general model

recommended by the Gibbs Report. The key features of the Taskforce recommendations were:

- the separation of funder (RHA) and provider (CHE, voluntary sector, private)
- integration of funding of primary (GP) and secondary (hospital) care
- public hospitals becoming crown companies (CHEs) with commercial objectives
- a regime of user part charges (Scott, 1996, p99).

At the next phase of health sector restructuring there was a more direct influence of the business sector on policy development. Critics such as Blank (2000) state that there is evidence of the significant influence of the Business Roundtable, of which Gibbs was a member, and CS First Boston NZ Ltd. The recommendations of the Roundtable's commissioned report by CS First Boston's visiting Professor Patricia Danzon (Danzon & Begg, 1991) 'Options for Health Care in New Zealand' were in turn key provisions of the health reforms initiated by Simon Upton as Minister of Health.

The Danzon report as it became known concluded that 'a private insurance option... could be viewed as a final stage towards which a mixed public/private system could evolve.... '. The report also makes reference to 'corporatisation... would also be a sensible transition path if more far-reaching reform is contemplated' (Easton, 1997, p157-158). This is a repeat of the similar path that Labour had trod in the belief that the public would oppose outright privatisation thus the objective could be more easily achieved through corporatisation.

CS First Boston were then commissioned to advise and provide guidance to the National Interim Provider Board on options for implementing the new health care provision structures. The National Interim Provider Board (NIPB) was a key agent in the transition to the next major phase for the reforms. It was located in the Department of the Prime Minister and Cabinet (DPMC) which was to supervise the establishment of the CHEs.

> The chairman appointed to the board was Sir Ronald Trotter, chairman of Fletcher Challenge Ltd, which had been an active purchaser of public assets. Trotter, a well-known spokesperson for privatisation, was also chairman of the Business Roundtable at the time of the Danzon report. He had no background in health administration. ...
>
> Its primary consultants were CS First Boston, the sponsors of the Danzon report, again without specialist experience in the health sector. The NIPB hired overseas consultants of a privatisation persuasion, including Danzon. Later it hired Peter Troughton, an ex-Roundtable member who as CEO had been involved in the privatisation of Telecom, again with no background in health administration (Easton, 1997, p158).

The 1990 National Government placed an emphasis on individual responsibility for health, access to core services was guaranteed to be affordable but not free. The state role was increasingly seen to be one of subsidising costs for those persons who were either unable to afford or who were high users of health care. Although the Government considered moves toward a social insurance system, it decided to retain the existing tax-based funding system, instead of a shift to a more radical private health system.

## The Funder Provider Split – CHEs and RHAs

The structure of the new health system emphasised the separation of purchaser and provider roles via the establishment of four Regional Health Authorities (RHA) to purchase services and 22 Crown Health Enterprises (CHE) to provide

services. The prevailing system of 14 Area Health Boards, which both purchased and provided services, was perceived as not producing the best value for the health dollar even though it was only fully implemented in 1989. It was believed that resources were locked into the maintenance of buildings and consequently boards were reluctant to look beyond their own facilities for better provision of service. Having funding and provision of services in the same body provided little incentive to develop efficiencies and cost savings. The new National Government considered that service providers who performed well were unable to be rewarded. "The emphasis was still on providing bricks and mortar, rather than providing best value health services" (CCMAU, 1996, p7).

A transitional process occurred throughout the period 1 July 1991 to 30 June 1993. Separation of the purchaser and provider functions required management, and the National Interim Provider Board was established to oversee the process. As an interim measure until the four RHAs went into effect on 1 July 1993, elected AHBs were abolished and commissioners were appointed to effect the transition. Crown Health Enterprises (CHE), while not yet established, were constituted as CHE Boards Designate.

The reform separated the purchaser and provider roles of the AHBs and established a competitive market approach to the provision of health services. Four Regional Health Authorities (RHAs) in 1993, instead of the six recommended in the Gibbs Report, were established to manage the purchasing of and contracting for health services in their geographically defined populations. Although initial plans called for the creation of alternative Healthcare Plans to

compete eventually with the RHAs for clientele, under considerable pressure this approach was dropped.

Four Regional Health Authorities were responsible for the purchasing of health services that best met the needs of their respective communities. There were three Regional Health Authorities in the North Island and one in the South Island. RHAs were to be funded by the Ministry of Health according to a population-based formula with weighting for certain geographical and demographic factors such as population dispersion and age of population. Regional Health Authorities were able to contract for health services with a wide range of providers, including the public, private and voluntary sectors. The competitive contracting mechanism was intended to produce efficiencies through the operation of a market, where the competing bids would provide the most efficient and cost effective price for services.

The four Regional Health Authorities were bodies corporate established by Order-in-Council and run by a board established by the Minister of Health. The objectives of Regional Health Authorities were defined in the Health and Disability Services Act (1993) as:

- promoting the personal health of people; and
- promoting the care and support for those in need of personal health services or disability services; and
- promoting the independence of people of disabilities; and
- meeting the Crown's objectives notified to it under section 8 of the Act- in accordance with, and to the extent enabled by, its funding agreement (Ellis J, 1994).

The RHAs were also given responsibility for purchasing primary care, thus devolving this function from the Department of Health and integrating it with secondary care.

Another key to the reforms was the reconstitution of the provider function of public hospitals into Crown Health Enterprises (CHEs) which were to be run on a business basis under the direction of appointed boards. These entities (CHEs) were incorporated as limited liability companies. Elected Area Health Boards were abolished and replaced by an appointed Board of Directors. The owners and shareholders of the CHEs were the Minister of Finance and the Minister of Crown Health Enterprises. A Board appointed by the shareholders ran each of the CHEs.

A government organisation, the Appointments and Governance Board appointed directors. The appointment criteria were based on skills and relevant experience in business, public or private sector and community management skills.

The principal objectives of a Crown Health Enterprise were stated in the Health and Disability Services Act (1993) as:

- Providing health services or disability services, or both; and
- Assisting in meeting the Crown's objectives under section 8 of the Act by providing such services in accordance with the CHE's statement of intent and any purchase agreement entered into by it, while operating as a successful and efficient business.

Subject to economic feasibility and government approval, smaller communities could opt to take over control and management of their local hospitals as Community Trusts (CTs). The funding of both CHEs and CTs was dependent

upon the winning of contracts for particular services. These bodies were potentially in competition with private hospitals and private and voluntary providers in a bidding process.

Traditional public health functions such as education, prevention, and public health research were to be carried out by the newly established Public Health Commission (PHC). The role of the PHC was to monitor and analyse the state of public health, advise the Minister of Health on health goals and objectives, and purchase public health services on a contestable contract basis. Traditional public health functions were separated from the general health system and given a direct support role in relation to the Minister of Health.

For the consumers of health services the most obvious example that the health system had been radically changed was the introduction of part charges for secondary care. Until the RHAs were in place (1993) and operating and able to set user charges, a national interim system of part charges for hospital and outpatient care was established, with subsidies for low-income families and high users (Blank, 1998). The introduction of part user charges provoked more hostility, non-compliance and confusion than any other change. This was the most obvious symbol that the National Government had broken the long tradition of free hospital care (Davis & Ashton, 2001; Easton, 1997).

### *Forms of Health Service Rationing*

Definition of what the government could be expected to fund was critical to the success of the reforms finally fully implemented in 1993. While the list of core services could not be defined other forms of financial and administrative rationing

were introduced. The reforms of the 1990s departed from the previously accepted universal access philosophy and focused on targeted assistance to specific groups.

In 1992 the government created a Community Services Card (CSC) scheme, which gave people on low incomes access to health services at reduced prices. The cards were available to members of families with an annual income of less than NZ$35,000 (Bloom, 2000).

> Cardholders included a high proportion of students and older people. The actual level of co-payment for each type of service varied around the country, in line with variations in doctors' fees for identical services. For those eligible under the CSC scheme, co-payments were generally set at approximately 50 per cent of the service provider's fee (Bloom, 2000, p94).

Other forms of targeting involved part charges for public hospital services. For subsidised hospital costs to be available for low-income families, charges were introduced for many hospital services for the wider population. In 1991, the government introduced a $31 charge for each hospital outpatient visit.

> The objectives of the new fee were mainly to reduce utilisation and to reduce the barrier to greater and fairer competition among service providers and service settings. The government argued that there was little sense in maintaining co-payments for general practice and medical specialist services in other settings while hospital outpatient services were free of charge (Bloom, 2000, p94-95).

The irony was that hospital management reported that the cost of collecting the new co-payments was approximately the same as the revenue they generated. The co-payment scheme was unpopular amongst the public and generated a lot of negative publicity and became a political liability. Unsurprisingly the co-payments were dropped shortly after they were adopted. As a strategy the co-payment scheme appeared to be ill considered without the implications thought through let alone the actual cost to administer (Bloom, 2000).

Elements of the Oregon rationing model were replicated to some extent by the National government. With the separation of the funder, purchaser and provider the government also attempted to define 'core services', those essential, central, or fundamental services that form part of what the government would provide for all citizens. 'Governments seek to define 'core services' in the course of health reform as a means of delimiting what government can reasonably be expected to finance' (Bloom, 2000, p95).

'According to the Minister it was a 'crucial' part of the health reforms 'probably the most important concept in the new health system' (Upton, in Davis & Ashton, 2000, p164). For the Minister of Health, Simon Upton, to have a defined list of services the government would fund was an important component of the reform programme. It would provide clarity for the public of the Government's commitment to what services would be publicly funded, individual entitlement to publicly subsidised health services and the overall intention to limit the growth of health expenditure.

Similar to Oregon the list of core health services was to 'reflect the communities priorities' and a government appointed committee, a National Advisory Committee on Core Health Services, was to be selected to engage in a process of public consultation about what should be included in the core list (Upton, 1991). The Committee was to then advise the Minister of Health on the range of services to be included in the core. The list of core services 'would be specified in general

legislation ... and would be enforced either through the general courts system or a specialist tribunal established by legislation' (Upton, 1991, p86).

The Minister of Health appointed the CSC in March 1992, to assist the Government in defining a core of services. The Committee consulted widely on the effectiveness and access of existing services. Despite the best intentions within seven months of its appointment the committee abandoned the notion of an explicit core. The members decided it would be 'impossible to implement' (Core Services Committee, 1994, p1). They claimed 'it would either have to be so broad as to be meaningless, or so rigid as to be inflexible and unfair' (Finlayson, 2000, p165).

The complexity and the political contentiousness of the task in the hostile reform environment of the time did not make the outcome surprising. The Committee shifted its focus from advising Government on which services should be provided, to assessing the terms of access to existing services.

> Rather than defining general entitlements, the committee became concerned with setting the terms for access to services at the individual level, claiming that the social and clinical circumstances of individuals needed to be taken into account when considering access to services. A list approach – that is, defining general entitlements in an explicit core of services – would have disregarded these factors (Finlayson, 2000, p165).

As a result of the decision to not define a core, the Ministry of Health set out in its annual Policy Guidelines for Regional Health Authorities the services RHAs were obliged to purchase on behalf of their clients. These were known as service obligations and lacked any specificity and detail of what services that members of the public might be entitled to from publicly-funded health services in New

Zealand. The outcome for the public was that ad-hoc covert rationing continued as before.

### *Health as Business*

The new structure and emphasis on commercial viability introduced in 1993 under the RHA system brought new lines of accountability to entities that hospitals and related services had not previously had a direct relationship with. The Crown Company Monitoring and Advisory Unit (CCMAU), a government agency affiliated with the Treasury, monitored Crown Health Enterprises (now known as Hospital and Health Services). CCMAU reported directly to the Ministers of CHEs and Finance, who owned the CHEs as shareholders on behalf of the government. Historically, hospitals had not had such a direct reporting relationship with Treasury. The accountabilities and reporting relationships have been and remain highly complex.

CCMAU described their role as being "to advise shareholding Ministers on the balance between public policy objectives and efficiency objectives, and identify trade-offs between them" (CCMAU, 1999, p8). Their core objective as stated was "to provide advice that protects and enhances the value of Crown companies" (CCMAU, 1999, p3).

CCMAU thus advised the Ministers of Health and Finance. Treasury also had a role in advising the Minister of Finance in respect of Health. CCMAU was significantly funded through the appropriations of its client agencies, in this case Vote: Health. Treasury had ultimate authority in preparing the government Budget, including Vote: Health (Steering Group, Ministers of Health, 1997).

The discernible disapproval and resistance of the public to many of these health sector changes led to proposed changes in the health sector becoming a key point of the election campaign for National in the 1996 election. Bill English, the new National Minister of Crown Health Enterprises indicated that if his government were returned it would ensure:

- The reduction of the four RHAs to one;
- The reduction of the number of CHEs to about half (the reforms had split 14 AHBs into 23 CHEs);
- The combining of the portfolios of the Minister of Health and Minister of CHEs (Easton, 1997, p163).

Effectively the National government was proposing a strategic retreat on some issues that appeared to return the health sector to centralised control.

Despite the initial 1990 intention to revolutionise the health sector the National government by 1996 had had to retreat on key goals. The government had already:

- abandoned health care plans (the public stated firmly it wanted no change in public funding);
- abandoned the Public Health Commission (PHC) as a stand alone entity charged with advising and monitoring public health;
- abandoned the core health services definition programme;
- withdrawn the hospital overnight charges and withdrawn or reduced some other user part-charges;
- failed to gain significant productivity gains;
- substantially increased public funding (rather than hold it, as hoped), yet various indicators (such as the length of waiting lists) had not improved or had deteriorated;
- increased the exposure of ministers to minor failures in the system (because previously the area health boards had taken responsibility); while
- despite their business goals the CHEs continued to make losses.

The 1996 OECD report on the New Zealand economy was reticent about the health reforms and what the gains may have been. Their report did not sound totally convinced of the projected gains and outcomes.

> .... even though the system is in its third year of operation, it is not yet clear how the reforms will ultimately affect health care in New Zealand. It is too early to observe their effects on health outcomes and to discern what impact they will have on output of the health sector as well as the organisation of output provision (Easton, 1997, p162).

After 1996, with the introduction of Mixed Member Proportional representation (MMP), no one party would hold an absolute majority in Parliament. Legislation would require the support of at least two or three parties particularly if major policy changes were involved. Effectively any succeeding government was locked into the 1994 legislation of the Fiscal Responsibility Act unless significant support could be harnessed from other parties to support any initiative that deviated from the principles.

### The 1996 National/New Zealand First Coalition Government

With the formation of the National/ New Zealand First Coalition government of 1996, the ownership relationship changed from the Minister of CHEs to the Minister of Health, who subsumed the Minister of CHEs' responsibilities. Ownership on the Finance side remained with the Minister of Finance, and was not passed to the new position of Treasurer.

## Hospital and Health Services and the Health Funding Authority

The change in name from Crown Health Enterprises to Hospital and Health Services (HHS) in 1998 was due to a further restructuring as a result of the governing coalition agreement entered into between the National and New Zealand First parties in 1996. The politicians argued that it was more than a name change as there was a shift from the requirement of CHEs to make a profit to Hospital & Health Services being required to act in a business-like manner. Other changes included the return of a level of direct community representation, with local Councils being invited to nominate two candidates for inclusion on CHE Boards, with the condition that they not be sitting Councillors. Health funding, which had been regionalised under the RHA model, began the process of transition to a single national health funder, the Health Funding Authority. That change was completed by October 1998.

## Evaluating Changes in New Zealand Health Service Delivery

New Zealand has experienced two sweeping health system reforms in the past twenty years: a reformed public health model under Area Health Boards introduced gradually through the 1980s and a more explicitly market driven and rapidly implemented model under Regional Health Authorities instituted in 1993. The reforms of the New Zealand health sector in the 1980s and 1990s have been driven by the prevailing ideology of the government of the day. The changes in the health sector were an integral both Labour and National governments model for the economy and consequently the public sector. Rationalisation for change has frequently been argued on the basis of cost and the need to contain cost. While the public expectation and government policy had been since the late 1930s that the demand for services should be based on need and be met and funded by

the State, the State in the 1980s and 1990s has explored models that have attempted to set finite limits on cost and types of health services that would be funded. Potential need can always outstrip funding potential in any health system. However, the changes in New Zealand, as elsewhere, included as maxims the shift from the government to the private sector and the development of a competitive model.

There will always be tension in funding (and rationing in some form is inevitable in any system). The shift was not totally about cost containment, but also a political shift to a new ideology, the free market, without the accompanying acknowledgment that the free market health system (the United States is the major and most developed example) also includes rationing to contain costs. That is, the large number of US citizens who are either uninsured or under-insured, the "gap" group and thereby receive inadequate or minimal health care access.

Over the last decade in New Zealand there has been an attempt to shift the burden of health care provision from the State to the individual. This has been ideologically driven not because the public has endorsed and accepted a new style of health care delivery. Since the 1930s there has been a strong belief within New Zealand society that free health care was a right that every citizen was entitled to. The exploration of other models that challenged the prevailing egalitarian philosophy has been influenced by international trends and solutions adopted by other governments, though in many respect can be seen to have gone further and faster than others (Boston et al, 1996). World Bank and International Monetary

Fund (IMF) influence has helped shape New Zealand economic and social policy in much the same way it has in large parts of the developed and developing world.

Examination of the recent market-driven New Zealand health sector reforms of the 1990s would initially suggest a radical departure from past policies. When examined within the trends in New Zealand health policy since the early 1980s these should more accurately be seen as further steps towards a major transformation of a national health care system, already under way by the end of the 1980s. This transformation has been driven by a number of factors, including:

- Technological advances
- Population changes
- Expanded public expectations for health care
- Realisation that NZ cannot afford to maintain a system formed at a time when the country had the third highest per capita income in the world.

After decades of living beyond its means and the accumulation of $50 billion worth of debt, the international pressures to reduce fiscal risk required a considerable scaling back of government spending (Blank, 1994, p129).

Clearly, the ideological shift of governments internationally away from the ideal of the welfare state has also been common to both main New Zealand parties since 1984. Whether health care is one of those services that ought to be transferred to consumers or whether it should be targeted to certain parts of the population is an ideological question concerning the type of society of which we wish to be a part. While the governments may have seen the abandonment of a universal state funded health system as necessary and desirable, "the public" was arguably not convinced, let alone consulted (Blank, 1998). For example, despite

the growth of the private sector the actual proportion of health funding from private insurance remained low. In 1992, while over a third of New Zealanders had some insurance coverage, and there were over one million members of Southern Cross alone, private insurance represented only about 3.5 per cent of total health expenditures (Blank, 1998, p273).

The successive Labour and National governments of the 1980s and 1990s had demonstrated that they were able to restructure the health system at will. This was achieved in several ways: the speed in which change was imposed, successive changes of Ministers, introduction of external advisers and consultants from the private sector. While Labour initially took a more incremental approach to the development of Area Health Boards, by the end of the 1980s they were mandating them through legislation, and replacing one by a commissioner. National then built on this precedent, mandating wholesale change through legislation and replacing all the Area Health Boards with commissioners. The impact of these approaches has been instability in the health sector for health professionals and confusion for consumers as they struggled to understand the implications for the sector and the shape of the new structure.

A major contributor to the instability has been the succession of health ministers, particularly since 1986. Each had differences in style and their personal vision for the role. With each new minister came new preferences and a new agenda for health reform. Within a three-year period (1987-90), Labour had Michael Basset, David Caygill, and Helen Clark. In 1991 National appointed Simon Upton who

was replaced in less than two years by Bill Birch, then followed by Jenny Shipley, Bill English and in 1999 by Wyatt Creech.

While it is not unrealistic to expect policy change when governments change, health policy is also subject to the personal agendas of changing ministers even within the same government. Blank has described the 4th Labour Government as particularly characterised by the dominance of individual ministers and the apparent inability or unwillingness of the government as a whole to offer a coherent and comprehensive health policy (Blank, 1994). 'At times this resulted in reversals in the implementation of major internal restructuring efforts, caused directly by fundamental changes in direction reflecting the different priorities of the individual ministers' (Blank, 1994, p133).

The New Zealand public health sector is one of the most complex of all sections of government, with accountability and role definition at times overlapping between agencies, and at other times seeming to leave a vacuum. The frequent recent reform processes have increased that structural complexity, and heighten the observer's difficulty in following the changes in influence and decision making. Those processes can highlight the apparent failings of government agencies in respect of the Treaty of Waitangi and health. Such failings may have as much to do with omissions occasioned through structural change and loss of institutional memory as with any intent on the part of the Crown.

### *Public Accountability*

Accountability in the reformed health sector is not a simple issue, even to the point of determining accountability at the local level for decisions.

> The organisational changes in the health care system and the public sector generally over the last twenty years, and particularly since 1984, are as cataclysmic as the post provincial revolution in government administration [1876]. Indeed, last years structural changes [1993] may become so epochal that previous healthcare history could eventually be referred to as BC (before the changes) and subsequent events as AD (after the Department.) These changes were achieved with significant staff losses, significant haemorrhaging of institutional memory, and management and organisational disruption, (Brunton, 1994, p136).

The changes to the core public sector led to a reduction in policy provision by the downsized public service, and the increased contracting of external private sector consultants in the development of health policy and refining the government's position (Boston, Martin, Pallot & Walsh, 1999). The public perceived these consultants as extremely influential and contributing to the marginalisation of the public and health professionals in the development of health policy (Blank, 1998; Blank, 2001). Public resistance to the health reforms also provided a pressure and influence on government policy (Easton, 1997).

The motivation for the use of external consultants was driven in part to avoid capture by the traditional interest groups and the desire of successive health ministers to achieve their own particular agendas with minimal opposition (Blank, 1994; Easton, 1997). These objectives have been met at a cost. Over the last two decades the result has been the replacement of health sector interests with business sector interests. This has created alienation of health professionals because of their exclusion, loss of good faith and sector reform fatigue due to repeated restructuring (Blank, 1994; Easton, 1997).

### *Generic Management*

Easton (1997) has argued that the reform model was wrong as it was based on the assumption that health was a generic product that could be administered by

generic managers. Within six months of their inception in 1993 the CHE boards which were made up of predominantly private sector business people recognised that the health sector was different. The Chairman of the Crown Health Enterprise Chairs' Consultative Committee wrote 'the CHE group are of the view that the business of providing is not a genuine commercial mode' (Easton, 1997, p164).

Central to the justification of the economic reforms (including specifically the health reforms) of the 1980s and 1990s was the theory that any able manager was capable of managing any agency in the private or public sector (Easton, 1997). The implications for the health sector were the replacement of specialist managers with institutional experience, with generalists with no institutional memory and little institutional experience. The most well known example of this was the appointment of the first chief executive officer of the largest Crown Health Enterprise who was previously involved in brewery management (Easton, 1997). The theory translates with this example that the same skills are needed to run a hospital as to manage a brewery and that the production of health services is not essentially different from the production of beer.

Such a theory inevitably led to serious tensions between clinicians and generic managers. Easton (1997) describes it as a clash of culture between generic managers focused on profit and clinicians focused on patients, with those that advocated for the reforms claiming the two objectives are much the same thing.

The clash of culture had some dramatic results. Within three years (1993-96) over half of the chief executives of Crown Health Enterprises had left and were having

to be replaced. Ian Frame, when CEO of Canterbury Health, wrote 'the professional and commercial cultures have come face to face in a way that has not happened before ... At present there are serious tensions...' (Easton, 1997, p170). Within six months of this statement Mr. Frame's CHE had a major industrial dispute with clinicians over work practices and remuneration and Mr. Frame had resigned.

### *Public "consultation"*

The sweeping policy changes of the 1980s and 1990s were deliberately conducted with few opportunities for public input by so-called vested interests (Douglas, 1993). The sense of alienation possibly contributed to the dramatic drop in the real participation rate of voters in the 1990 general election that fell to a fifty-year low with 24 per cent of eligible New Zealanders failing to either register or to vote.

> In 1989, the percentage of New Zealanders reporting 'full trust and confidence' in politicians had fallen to 4 per cent, compared with 33 per cent in 1975. But perhaps most disturbing are the results of a 1991 survey, which revealed widespread feelings of cynicism and powerlessness in the electorate (Hayward, 1997, p409).

In the 10 years 1987-97 there were over 373 instances of the use of the word 'consultation' in new legislation (Hayward, 1997). The term 'public consultation' referred to lay community involvement in the policy process, where the responsibility for decision-making ultimately remained with elected representatives or their officials. In a landmark ruling in the High Court (Air New Zealand Ltd vs Wellington International Airport Ltd, 1992) Chief Justice Mr McGechan defined public consultation as: 'The statement of a proposal not yet finally decided upon, listening to what others have to say, considering their responses, and then deciding what will be done.' He went on to state that

consultation was not 'merely telling or presenting information'; nor, he argued, did it necessarily involve '... the negotiation toward an agreement, although the latter not uncommonly can follow.... Consultation is an intermediate situation involving meaningful discussion' (Hayward, 1997, p411). His ruling defined the essential elements of public consultation. They included: providing sufficient information to consulted parties; ensuring sufficient time for public consultation and subsequent deliberation on advice; genuine consideration of the advice given; and an open mind and willingness to change.

Consultation with the public in the 1980s and 1990s became a parody of how to consult without really consulting. It became a one-way process of convincing the public and health community that the policy selected was the best for society (Douglas, 1993). Labour and National governments had, once in power, the political capacity to initiate policy change without effective opposition. Consultation on social policy moved from being a pre-policy-making activity to being a post-policy-making activity. Instead of explicitly initiating public debate before the policy was made, public relations efforts were used to post-hoc educate the public or to sell the policy at the implementation stage (Blank, 1994, p135).

Public consultation has had important symbolic significance in that the policies ultimately made were viewed as the result of democracy, despite the fact that most of the public did not actively participate. In their desire to escape capture by special interests, recent governments even jettisoned the symbolically important

perception of having sought public input at the initiation and estimation stages (Blank, 1994, p135).

In 1993 the National Government launched an advertising campaign to convince and educate the public of the benefits of the health sector reform and the new system. The $2.5 million dollar campaign did not have the desired outcome that the government may have wanted. The advertising campaign was seen as overt political advertising that increased public resistance to the new reforms not acceptance. Resistance from the Coalition for Public Health, which included a number of retired and active sector participants, gave a public face and voice to the general public's disquiet (Easton, 1997, p159). Easton suggests that the campaign was a failure as the Prime Minister transferred the health portfolio held by Simon Upton to Bill Birch, 'Any campaign whose commander is replaced must be judged a failure' (Easton, 1997, p161). Birch drove through the reforms to the establishment of the CHEs and RHAs on time in July 1993. However, while the structural changes succeeded, many of the policy changes did not (Easton, 1997).

### *Public representation*

The National government's (1990-1993) own actions reinforced the sense of alienation for sectors of the community. They ignored established public consultation procedures and practices, with the market-oriented policy reform process that started in 1984, as evident in the government's decision to dismantle the elected hospital boards. Local communities first elected hospital boards in 1909. This had been a tier of local government in which women were active participants with reasonable representation.

> ... In 1989, 53 per cent of all elected candidates and one-third of board chairpersons were women. In 1993, these elected boards were dismantled. They were replaced by government-appointed boards charged with the task of running the newly created Crown Health Enterprises (CHEs) and Regional Health Authorities (RHAs). In an ironic twist, this reform took place in the centennial year of women's suffrage; yet fewer than one third of the new government appointments were women, and only one of the twenty-three new CHEs was chaired by a woman (Hayward, 1997, p410).

For the public of New Zealand the claims before the health sector reforms of substantial and rapid improvements that justified the costs of the upheaval were not substantiated. Jim Bolger who led the National government through the duration of the reform process acknowledged there had been a high political cost to the health reforms (Easton, 1997). The government's health policies were identified as a major reason for the substantial loss of support for National in 1993, in which it lost a quarter of its 1990 vote, though still maintained power. While the public in general may have reacted negatively to the health reform process, the issue of its success or failure for Mäori is separate.

The next chapter provides an overview of the impact of reform changes on Mäori. In particular, it highlights the development of Mäori health initiatives outside of the mainstream health sector during this period, and considers the extent to which that development may be said to address the Crown's responsibility for Mäori health under the Treaty of Waitangi.

# CHAPTER 5 KAUPAPA MÄORI HEALTH INITIATIVES: 1983 - 1997

## Kaupapa Mäori (By Mäori for Mäori) Health services and their development

In 1984, at the beginning of the structural reform period under study, a crucial hui addressing the question of Mäori health was held at Hoani Waititi Marae in West Auckland (Dept of Health, Hui Whakaoranga: Mäori Health Planning Workshop, 1984). The participants were a range of Department of Health, Mäori Affairs, and Hospital Board representatives, as well as representatives of Iwi. The then Minister of Mäori Affairs in the National Government, the Hon. Ben Couch stated, '.... there is no such thing as Mäori health or Pakeha health; there is only people health'. In his view, the individual was to blame for the state of their health '.... most people who enjoy good health have earned it. The rules are the same for people of all races; good eating, plenty of sleep and exercise, and moderation in all things' (Durie, 1994, p67).

While that may have been Mr Couch's view, Hui Whakaoranga rejected that position. The hui recommendations advocated that 'health and educational institutions recognise culture as a positive resource' and that 'the feasibility of including Mäori spirituality in health education programmes in schools and in tertiary educational institutions be investigated' (Durie, 1994, p67).

Hui Whakaoranga is significant in the development of Mäori health initiatives, as it was the first national health hui held. The participants, a wide range of Mäori health professionals, academics and health care providers, supported Mäori health initiatives and advocated the provision of health care programmes by Mäori. Over the next six years considerable progress would be made in the development of Kaupapa Mäori health programmes.

## 1980s - Mäori Public Health

Debate within Mäoridom regarding the comparative health status of Mäori had been occurring for a long time. Tainui had had a particular interest dating back to the public health programmes of Te Puea in the early 1900s.

> It was during the chickenpox outbreak that I first commenced my work. That was in the year after King Mahuta died. I was living on my farm at Mercer at the time. I found that Mäori people were dying by the riverside. We could get no nurses for them. I had very little money so all my sister and I could do was to make a camp from Nikau palms at the river and there we nursed as many as possible back to health (Ramsden, 1927).

As I have noted elsewhere (Ferguson, 1997), Tainui Iwi were among the first developers of indigenous health initiatives within New Zealand. The Waahi health model was developed in the early 1980s (Ferguson, 1997). The model grew out of a desire by local people to have greater control over their own health status. It was catalysed in part by the visit of Dr Corinne Shear-Wood, a visiting American medical anthropologist, who was sponsored to work with the Waahi community by the Centre for Mäori Studies and Research at Waikato University.

Dr Shear-Wood had extensively researched cultural factors influencing the health of indigenous people. Two key findings emerged from her several months of residence at Waahi Marae, that 'the marae is an invaluable adjunct to maintenance

of Mäori health', and 'the Pakeha medical profession continued to ignore the marae as a potential resource for the delivery of health services' (Shear-Wood, 1982). She concluded her study with the view:

> that considerable improvement for the Mäori people in Huntly - in health conditions in general and blood pressure levels in particular - could be attained in direct ratio to the extent that the strengths and acceptability of the Mäoritanga are utilised. Specifically, the establishment within the Marae setting of a minimal health facility, would benefit from the trust and confidence the Mäori people experience in such an atmosphere. For the Mäori people involved in this study, it is apparent that the Waahi Marae offers an ideal location for such an innovative Mäori Health Centre within the Huntly community (Shear-Wood, 1982, p37).

She anticipated the centre providing a focus for a mix of health education and primary prevention work, work that fitted neatly within the role of the Department of Health of the day.

> The proposed facility could be used for examination, treatment, health education, and for the training of primary health care workers who would constitute the essential out-reach liaison component. The services of a general practitioner on a one day weekly basis, a dentist on a one day monthly schedule, and a nurse/health educator in attendance on a half-time arrangement would constitute a low cost, skeletal, but adequate, work force (Shear-Wood, 1982, p37, 38).

Primary health care workers were an innovation at the time and had been advocated by the World Health Organisation (1978). Three or four workers would be recruited from within the Waahi community. The control of the project, its direction and guidance were to rest with the community, making it a true kaupapa Mäori health initiative.

This concept of marae based health care was not what the Waahi community had been used to. Primary health workers had an interesting time working with the community to redefine their views of health. 'At that time health was sickness. Right away you thought of doctors...' (Matatahi, 1996). The Waahi community

supported the proposed initiative, and in September 1981the Centre for Mäori Studies and Research, submitted a pilot proposal on their behalf to the Minister of Health, to test the feasibility of a marae based health project. The then Minister of Health George Gair viewed the proposal favourably:

> the proposal was in line with an approach formulated at a conference for Mäori doctors which was held in Wellington in September 1981...the philosophy of self-help in the preventative and clinical aspects of health had much to commend it and Waahi Marae could be seen as a pilot scheme (Van Meijl, 1987, p11).

A formal proposal was prepared and submitted in November 1982.

> The proposed centre was to be a community based, community staffed and community controlled health facility. Its focus was to be on the maintenance of health in its physical, mental, emotional and spiritual aspects. Just as the meetinghouse represented Mäoritanga, and the whare kai represented hospitality, so the health centre would represent health. It was emphasised that the project should never become a sickness or clinical service, as health is more concerned with habits and beliefs than with disorders and disease (Van Meijl, 1987, p11).

The governance of the centre was planned to remain largely with the Waahi marae community. The kaupapa of the training programme was the integration of Mäori cultural values and beliefs, traditional Mäori healing practices and modern preventative health knowledge.

The proposal was supported by organisations such as the New Zealand Cancer Society and the New Zealand Diabetes Society, who saw it as improving the access of Mäori clients to their services and increasing the availability of community health information. General practitioners did not have such a favourable view, believing the new role encroached on the preventative work they were already undertaking.

> ...At that time only one per cent of health funding was going towards prevention and doctors they say they were doing prevention but we were saying they weren't because people had to be sick to go and see them to

> prevent it but whereas we wanted to stop them from being sick... The opposition was strong [from doctors] Who were these two Mäori women with no qualifications.... Who were those two to come and speak to the diabetes conference at Waikato? (Matatahi, interview, 1996).
>
> They thought Tutata and I were going to go out and tell all these Mäoris they shouldn't smoke and the dangers and so on. We didn't really have a relationship with them at all because we weren't qualified we were just in the community...There really wasn't much support from our local doctors (Te Hemara-Maipi, interview, 1996).

The community health workers believed that the improved access to information would impact positively on the health of the individual and consequently reduce the cost of health care on the tertiary level.

> If they could get clientele that became informed and they were able to come off their medication or if they avoided going into hospital we were actually going to save thousands and thousands of dollars for the taxpayer (Te Hemara-Maipi, interview, 1996).

The Waahi Health Centre always had a strong community and individual empowerment focus. A fundamental aim of the Health Centre was to raise the awareness of the people of the community so they were able to take increased responsibility for maintaining their own health.

> We were trying to deliver a health message but the impression was, or the interpretation used to always be, that we would pick up on all these delinquent people who weren't doing the right thing. Even today I absolutely refuse to be part of that environment...We were challenged time and time in the institutions to go and talk to groups of kids that were naughty and I'd think hey hey this is not about kids being naughty we were in there to give a buzz about being Mäori, a buzz about what we were wanting to share...No way would we pick up on groups of our rangatahi that they were identified as being troublesome.... We said no that we there to give a positive message (Te Hemara-Maipi, interview, 1996).

The Waahi model was firmly based in principles of community empowerment. It argued that health did not belong to doctors and institutions. Health equalled wellness and the model believed the key to this was self-responsibility. With

health education and promotion people could make choices that would promote a healthy lifestyle.

The philosophy of the early health initiative was based on the recognition that 'The state of Mäori health is serious and is a concern for all Mäori people working in health and related areas' (Ave & Maclean, 1991, p24). As a result of this:

> Programmes that have a preventative bias, educative approach, offer social support by Mäori people for Mäori people, and others who feel they would like to avail themselves of this type of service, should be encouraged and supported by the present health system (Ave & Maclean, 1991, p25).

There was great national interest in what was being done at Waahi. The tribal development aspirations occurred at a time when the Department of Health was seeking to develop improved means of accessing Mäori (Ferguson, 1997). Waahi developments coincided with the development of strong public health philosophies within the health sector, prompted in part by the Alma Ata declaration (1978). Area Health Boards were being promulgated to achieve similar public health ends, however there was no specific overlap in the Waikato between these two developments (Ferguson, 1997).

The Waahi model was hailed as innovative and at the cutting edge of changes within health care delivery. It incorporated the development concepts - autonomy, control and working for the collective good which were guiding Tainui. It provided an example for other marae within the Iwi that was soon to be picked up by others throughout the land. The aims of the Waahi initiative and those which were later modelled on it were primarily:

> To reinforce that the Waahi Health Centre is a preventative centre that will be a resource pool for all marae, where health is taught rather than where sickness is cured (Ave & Maclean, 1991).

The focus was on health, development, and empowerment under a local kaupapa. As the decade of the 1990s health reforms arrived that focus was to change considerably.

## 1990s - Mäori Medical Entrepreneurs

### Primary Mäori Health

The market-driven health reforms introduced by the National Government from 1991 led to two new developments within Mäori health initiatives. These were the introduction of primary medical (GP) services at marae based health centres (Te Puni Kökiri, 1993) and the development of urban authority health centres not affiliated to a traditional Iwi based marae providing standard general practitioner service (Cunningham & Kiro, 2001, p75). Mäori recognised the reforms offered an opportunity to access funds through the delivery of primary health care services within a competitive market (Te Puni Kökiri, 1993).

Mäori health status was recognised as significantly worse than that of non-Mäori.

> Risks for Mäori were especially high for respiratory disease (hospitalisation rate of 2.2 times as great), diabetes (2.1 times), cataracts (1.9 times), kidney disease (1.5 times), circulatory disease (1.5 times), female reproductive system disorders (1.4 times), and complications of pregnancy and childbirth (1.3 times as high as non-Mäori) (Durie, 1994, p131).

There were two related responses from Mäori to the abysmal picture of Mäori health. Firstly, it was argued that the Mäori view of health needed to be recognised, and to influence how health care was delivered in main stream health services (Durie, 1994). As noted earlier the late 1980s included an emphasis by the Ministry of Health on biculturalism and the implications for health of the

Treaty (Dept. of Health, 1987,88). Commitment to the Treaty was demonstrated by partnership arrangements that some Iwi entered into with Area Health Boards, an approach endorsed by the report of the Ministerial Advisory Committee on Mäori Health (1990). The employment of community health workers nationally to promote health and provide programmes recognised that the needs of Mäori communities were different and required different solutions (Cunningham & Durie, 1999).

Article Two of the Treaty was fundamental to the second response. The increased emphasis on a Mäori perspective in health care services coincided with the "mainstreaming" of Mäori services into the wider state sector agencies and the devolution of Department of Mäori Affairs functions to Iwi. The demand for main stream health services to recognise and allow for Mäori involvement was mirrored by the strengthening of Mäori aspirations for autonomy and independence from the State (Durie, 1994). The development of kaupapa Mäori or "by Mäori for Mäori" services began to accelerate (Ministry of Health, Coordinated Care For Mäori, 1995).

In 1994 Mäori health was identified as one of the Government's four health gain priority areas (Policy Guidelines for Regional Health Authorities, 1994/1995). The Core Health Services Committee had made recommendations in October 1992 that during 1993/1994 more emphasis should be placed on 'ensuring that primary care for Mäori is effective, available, and provided in forms that encourage use by Mäori for health maintenance, health promotion' (MOH, 1993) After the RHA model health reforms of the early 1990s:

> Primary health care services were recognised as singularly important and an obvious focus for positive health development. Health promotion, disease prevention, and early intervention were to be part of an accepted Iwi package of services and were increasingly viewed by Mäori as services which they themselves could provide in a more effective manner (Durie, 1994, p161).

With the de-regulation of health services (1991) it was now possible for Iwi to be providers of health care. Iwi such as Tainui had already gained expertise in the establishment and management of health programmes during the 1980s. The contracting opportunities that were now possible under the Regional Health Authority model for defined services offered Iwi the chance to compete with other providers for service delivery. As Mason Durie argues:

> ...Iwi participation in the reformed health sector did not represent a new or even renewed interest. Instead, the reforms simply allowed plans and programmes already in place to find new expression. While there was an initial disquiet as Area Health Boards disappeared to make way for Crown Health Enterprises, in the long run Iwi were interested in the health of their people within a context of Mäori development. Of secondary importance was the shape of the health sector; it was, after all, only one aspect of the Mäori development mosaic and certainly not the entire focus (Durie, 1994, p164).

After 1992 there was a shift in the style of health care being delivered on marae and the numbers of Mäori involved in health care delivery. The emphasis swung from a focus on health to an agenda of Iwi development (Te Puni Kökiri, E Mua Kai Kai, 1993).

Tainui had been among the first Iwi to enter the health reforms as primary health care providers. Up until 1993 health development within the Iwi had been under the auspices of the Tainui Mäori Trust Board. The Waahi Health Centre arising from the report of Shear-Wood had provided the example and health development had been further built on with the Tainui Health Plan (Tainui Mäori Trust Board, 1990).

After 1993 there was a shift away from the Health Plan by the Waahi Health Centre management committee and the previous style of development. The new focus became providing medical services and a medical practitioner was employed. This appears to have been significantly due to recognition from the management committee of the control and gate-keeping role played by doctors in primary health funding. All of the primary health funding sources identified by Tainui (Te Puni Kökiri, 1993) required the presence of medical staff. Indeed, they identified the prospect of capitation funding as attractive, both because of its reliability, and the ability to broaden the funding to a range of non-medical services (Te Puni Kökiri, 1993). Clearly, medical staff availability became a key factor in achieving Tainui health service delivery ambitions, ironically at the cost of the broader preventive health development model that had initially inspired the service.

In the period 1992 and 1993 additional primary health services were implemented in the Tainui health initiatives. These included the establishment of medical practices and the employment of doctors and practice nurses. Doctors were employed on salary at the Iwi health centres as it was alleged that the difficulty in accessing medical care was primarily because of cost to the patient. This created a barrier to health care. A report states that:

> The presence of Tainui in the primary health sector is intended to address these barriers, thereby putting medical help and medication within the reach of Mäori.
> Many communities are disadvantaged through poor transport, and limited services. Some services can be made more accessible; and in the case of Tainui, by providing marae-based clinics and delivering basic health services to the 'front door'. Location is therefore paramount in the delivery of health services for Tainui (Te Puni Kökiri, 1993, p9).

Waahi Health Centre continued to provide an example for the next phase of development with the establishment of the RHA model in 1993. The medical practice at Waahi was established utilising the new RHA contractual arrangements the 1993 health reforms allowed. The Waahi Health Centre owned the medical practice and the doctor was contracted by the Centre to provide a general practice service for an identified patient group. Capitation as it was called enabled initiatives to have improved access to funding as the patients were registered with the practice not with the doctor.

> Capitation is an alternative arrangement with the RHA to provide general medical services on a contractual basis. It replaces the normal process for claiming General Medical Subsidies, which is fee-for-service based. Normally a general practitioner would claim GMS each time a patient eligible for a subsidy visits. In comparison, the capitation scheme uses a funding formula to work out an annual fixed amount to be paid for each patient eligible for a subsidy irrespective of the number of visits. Capitation funding, unlike GMS, is not demand driven and provides a more predictable and stable form of funding (Te Puni Kökiri, 1993, p17).

The Health Centre carried all risk and owned all profit. This provided Mäori health initiatives increased access to the health dollar. Patients benefited financially by having to pay no fees in the case of beneficiaries or a contractually limited low fee for others.

Once this new arrangement was refined there was a tremendous growth in the number and styles of Mäori health centres and not all of them were marae-based. After 1991 health and the delivery of health care was seen more as a business opportunity by entrepreneurs in contrast to the original kaupapa of the marae-based initiatives (Ferguson, 1997). With the establishment of Raukura Hauora (a corporate body distinct from Tainui governance) in 1992, Tainui entered the business of primary health care with a vengeance.

Within the Tainui leadership and other Iwi health initiatives concern has been expressed at the expansion of Raukura Hauora and the growth of health centres that are not marae-based (Ferguson, 1997). The majority of Tainui health initiatives from 1993 did not evolve out of a similar process to that of Waahi Health Centre. The introduction of doctors created debate within the Tainui Iwi as to whether the prevention and promotion message is being undermined. The new model, health service as a business (Maipi, in Te Puni Kökiri, 1993), changed the paradigm from one of employment of Mäori health workers to contracts with doctors to provide services that met capitation requirements from the RHA, i.e. personal health care and clinical treatment services.

There was concern that the Iwi has lost control of health development and an independent group within the Iwi has captured health (Ferguson, 1997). Comments have been made by other Iwi and marae based health care providers that Raukura Hauora viewed marae as business opportunities or competition (Ferguson, 1997). It is clear that Raukura Hauora grasped the contracting opportunities that the 1991 reforms provided. However the opinion within Tainui is split as to whether those opportunities have been at the expense of the development emphasis and the early promise of health status improvement to be delivered under this model.

### Mäori Secondary Providers

By the end of 1997 several Mäori health organisations in various parts of the country were looking to establishing secondary (hospital based) Mäori health services. These were generally brought about by shifts in the requirements for

hospital stock, as services became more specialised, and tended to concentrate on larger urban centres.

Two examples are immediately evident. The first is that of Ngati Porou Hauora, which took over the running of Te Puia Hospital north of Gisborne, when it was no longer an asset to the Tairawhiti Crown Health Enterprise (Durie, 1994). The second is Hauora Waikato, which grew out of the Mäori health service established in Tokanui psychiatric hospital in the early 1980s (Durie, 1994).

Both examples have the same thing in common with Mäori primary health care initiatives, the shifting of cost or risk from the Crown to Mäori organisations. Taking on the risk has brought organisational benefits, with the independence of running small and not so small businesses, and consequent employment benefits. However, any positive impact on Mäori health status as a result of that risk-taking has yet to be comprehensively quantified.

### Mäori Purchasers and Funders

A further development as a result of the 1990 health reforms was the development of purchasing and funding relationships between Mäori and the Crown. Several Regional Health Authorities entered into different types of arrangements with Iwi or Mäori health providers, in order to ensure their engagement and participation in the reforms. The most persistent model has been that of MAPO, or Mäori Purchasing Organisations, established by way of Treaty partnerships between North Health (the Northern Regional Health Authority) and various Mäori organisations purporting to represent Iwi in that region.

## Mäori Health Provision - a success story?

To answer the question, has Mäori health provision been a success story, we have to ask first, by what criteria, by whose point of view. There is no doubt the Ministry of Health views it as a success story, and furthermore one for which it takes a great deal of credit. Ria Earp, Deputy Director General of Mäori Health rates the significant growth of Mäori health provider numbers as an achievement the Ministry can lay claim to. And certainly on the face of it, the numbers are impressive: 20 providers to 240 in the last decade, and a budget increase from $300,000 to $110 million (Earp, 2001).

However, that latter figure needs to be put in context. The national budget for publicly funded health services in 2001 is on the order of $7 billion. Spending on kaupapa Mäori health services amounts to 1.6% of that figure, or about a tenth proportionally of the Mäori population.

One must look further into what constitutes a kaupapa Mäori service. As the previous section indicated, what was initially framed at Waahi as a strongly community based preventative and health development service has shifted over the past ten years to a model of medical entrepreneurship which is driven by financial development as much as any other kaupapa.

Even where the kaupapa has remained Mäori, in many instances the service provider, and particularly the medical service provider, is not Mäori. The service itself is provided within a mainstream medical model in many instances.

Clearly, however, from the view of the health reformers themselves, the risk shifting of unlimited primary health care demand from the Crown to Mäori primary providers has been a success. So much so that the same strategy has been adopted with some success in the mainstream primary healthcare environment, with non-Mäori providers grouped together as Independent Practice Associations (IPAs) (Midland RHA, 1995).

The current Labour-Alliance government's Primary Health Strategy reiterates the view that Mäori health care provision has been a success.

> It is essential that these (recent gains in Mäori health care provision) are not lost. District Health Boards will continue to contract with Mäori providers, and support their further development, so that Mäori communities have control over their health and wellbeing (King, 2001, p11).

Arguably, while the strategy met government goals in the 1990s of addressing Treaty issues in respect of Mäori health care provisioning, it could equally be seen as having suited their market ideology to create a competitor to the State. Thus, meeting Treaty of Waitangi obligations may have been coincidental with other motivations, whose longer term implications may be counter to the State's partnership obligations to Mäori, such as the development and failure of Mäori provider organisations in a competitive environment.

Before leaving the issue, it is important to reiterate that, even with the massive growth in Mäori health service provision under Article II of the Treaty, it amounts to only 1.6% of the Crown's health budget. Furthermore, Mäori utilisation of kaupapa Mäori health services is comparatively small, with the Ministry of Health estimating it at about 20% of all primary health utilisation by Mäori (Manaia,

interview, 1997). For this reason, the research in this study concentrates primarily on the Crown's responsibility under article III of the Treaty of Waitangi, and the provision of mainstream health services to Mäori.

The next chapter provides a detailed case study of the impact of a particular reform initiative on the delivery of Public Health services to Mäori in the Hawke's Bay. Mäori in the Hawke's Bay took a claim to the Waitangi Tribunal concerning the delivery of health services. The chapter sets out the basis and scope of the claim, and provides a detailed history of the decisions by the Crown agencies that led to a change in health service delivery. It concludes with an examination of those decision-making processes in light of the Treaty of Waitangi and its principles.

# CHAPTER 6 – WAI 692: A CASE STUDY OF A MAINSTREAM PUBLIC HEALTH SERVICE REFORM IN LIGHT OF THE PRINCIPLES OF THE TREATY OF WAITANGI

## Wai 692 – Napier Hospital Services Claim, Waitangi Tribunal 1999.[2]

The New Zealand health sector reform process of both the 1980s and 1990s has been portrayed as the seeking of improvements to the current services and the subsequent benefits to the consumer (Upton, 1990). The advocates of reform have assumed that their changes would bring automatic improvements and be better than what had previously existed (Upton, 1990).

It will be argued here that the reform process across the whole of the state sector, particularly in health, has not recognised the rights of the other Treaty partner adequately. For some Mäori communities the health reforms have left them with increased barriers to accessing health care, a less responsive service and what they would describe as a diminished service (Ferguson, 1998). As a Treaty partner the Crown has embarked on several radical restructurings of the health sector with at times little if any acknowledgment of their obligation to the other Treaty partner (Upton, 1991, Dept of Health, 1993)

---

[2] The author was commissioned by the Waitangi Tribunal as the principal researcher for the Wai 692 claim. However, this did not provide unfettered access to information regarding the decisions to close Napier Hospital, as several Crown agencies refused to allow her to interview staff or Board members, or restricted the range of material that could be covered by interview.

Post-recent-health-reform Mäori have, by default, a health system that has significant regional variation in the development of Treaty relationships between the Crown and Mäori, varying degrees of access to services, regional inconsistencies in the development of by Mäori for Mäori services, and minimal Treaty partner recognition of the right to participation, representation and consultation in the key decisions of the health sector.

> "While the significance of the Treaty is acknowledged by many, the principles are not protected by statute. Experience has shown that implementation of the principles of the Treaty has been subject to repeated negotiation with ever-changing health bureaucracies. Historical contractual relationships, such as the gifting of land for hospitals in return for free health services, may be subsumed when resources, previously under the guardianship of the Crown Treaty partner, are being transferred to Crown Health Enterprises." (Pomare et al, 1995, p27)

For some Mäori communities these health sector reforms changed the structure of health service delivery in a way that they perceived as detrimental to their collective health and well being (Ferguson, 1998). The exclusion of Mäori from the process and a refusal to recognise their Treaty partner status led to Waitangi Tribunal claimants from Ngati Kahungunu challenging the Crown's accountability for the health reform implications specific to their region of Hawke's Bay. This was the first health claim to be heard by the Waitangi Tribunal and will be used here as an illustrative case study to further the argument of this dissertation.

The chapter consists of a short introductory section setting out the basis and changing scope of the claim. A detailed review of the decision-making process, begun in 1980 and leading to the eventual closure of Napier Hospital follows. The process involved many Crown agencies, and the Crown acting at many different

levels, and illustrates the degree to which fragmented and changing entities, subject to both external and internal reform processes have led to the Crown overlooking its obligations to Mäori health in the reforms. The principles of the Treaty of Waitangi (discussed fully in Chapter 2) provide a useful evaluative framework to judge the extent to which the Crown may have overlooked Mäori health interests. Each of the three principles, consultation, participation, and representation, are applied in turn to the decision making process. The Crown is shown, through intent or neglect, to have acted in a unilateral fashion in respect of the Napier Hospital closure, and to Ngati Kahungunu in respect of the reform process in general.

## Wai 692 Claim Basis and Changing Scope

In 1997 a claim was made to the Waitangi Tribunal followed by a request in January 1998 for an urgent hearing to prevent the reduction of services provided at Napier Hospital. At the time of the request for an urgent hearing the concern of the three claimants who lived in the local community of Napier was the possible social impact closure of Napier Hospital would have on the Mäori community.

> That the Crown is in the process of altering the provision of health services in this area (Napier). The degree of alteration is substantial in that a hospital and community based services which were, until very recently, providing services of a significant level are being rapidly depleted to a point where all that will remain are very basic services.
>
> The information supplied by the CHE suggests that the services in Napier will be little more than a pit stop for minor medical matters. Earlier assurances from the Crown that Napier Hospital would continue to be the site for provision of those services have now been recanted upon.
>
> In addition to on site services there also appears to have been a proposal to reduce the availability of various community-based services such as home help and District Nurses.
>
> The claimants fear for the health of their people. They honestly believe that the degree of medical services which are now and will be available to

> the people of the Ahuriri region are nowhere near sufficient to meet the reasonable health needs of those people (Counsel for Urgent Hearing, Wai 692, 1998)

Urgency was not granted and the Waitangi Tribunal heard the claim in June and July of 1999.

The focus of claim Wai 692 or the Napier Hospital Services claim as it was known was originally on the reduction of services at Napier Hospital located in Napier city. Napier Hospital provided a comprehensive acute surgical, accident, medical and maternity service with related services such as x-ray, laboratory and physiotherapy. The Board of Healthcare Hawke's Bay, that administered Napier Hospital, decided originally in 1994 and reconfirmed in 1995 to stop the duplication of services by two hospitals in the region, Napier and Hastings, and resource a regional service on the Hastings Hospital site. This provoked wide spread debate within the Napier community. "No issue has ever created such polarisation and divergence of views across Hawke's Bay" (Napier City Council, Residual Health and Hospital Services for Napier City, October 1996, p1).

Several attempts were made to stop the development of a regional service at the expense of the Napier Hospital. This included court action taken by the Napier City Council against Healthcare Hawke's Bay (HCHB) in 1994, public rallies up until early 1998 to publicise the community's opposition and an attempt to introduce a private Member's Bill to Parliament to provide for the continuance of Napier Hospital in 1994. None of these actions dissuaded HCHB from proceeding with the closure of Napier Hospital, which they achieved in October 1998.

The Third Amended Statement of Claim (Waitangi Tribunal, 2001, p401) that the claimants filed in 1999 widened the scope of the claim. They cited two Causes of Action, firstly breaches of historical undertakings between the Crown and tangata whenua, and secondly contemporary Treaty breaches arising from the health reform process, as outlined below;

> 4. Pursuant to the terms and principles of the Treaty of Waitangi, from 1840 the Crown was and remains under an obligation to provide for the health and well-being of Mäori including:
>
> 4.1 Consulting with Mäori on substantive matters affecting Mäori health (Article 1).
>
> 4.2 Ensuring that Mäori are given control of adequate and appropriate resources within their communities (Article 2).
>
> 4.3 Ensuring that Mäori are in receipt of the same standards of health care and health outcomes as other citizens of New Zealand (Article 3).
>
> 6. ... The Crown retained the land subject to the 1851 Ahuriri transaction and:
>
> 6.1 Failed to consult with or otherwise adequately ascertain Mäori health needs at Ahuriri including failing to provide for adequate Mäori representation and participation in health agencies in Ahuriri including the Hawke's Bay Hospital Board, and
>
> 6.2 Failed to give any control over the delivery and administration of health services and resources to Mäori, and
>
> 6.3 Failed to fulfil its promise to establish appropriate health services, including hospitals and resources so as to ensure Ahuriri Mäori enjoy the same standards of health care as non-Mäori.
>
> 8. Since 1988 the Crown has reorganised the provision of public health and hospital services through the creation of a number of entities variously described as Area Health boards, Ministry of Health, Regional Health Authorities, Health Funding Authority, Crown Health Enterprises, Health and Hospital Services, and (to the extent that it is involved in the provision of or monitoring of health services) the Crown Company Monitory Advisory Unit ("Crown Health Entities").

> 12. In breach of the obligations under the Treaty and the Mäori Health Policies, the Crown and Crown Health Entities (including individual entities) have failed to give effect to the principles of the Treaty and Mäori Health Policies. (The Third Amended Statement of Claim (by the Wai 692 claimants,) Waitangi Tribunal, 2001, p401)

Critics, such as Bill English the Minister of Health at the time, described the claimants and others challenging the closure of the Napier Hospital as voicing a parochial response of resistance to change (House of Representatives, 1997). The response of Bill English to the Bill to prevent hospital closure was dismissive of any need to refer the Bill to select committee. He believed the people of Napier had had plenty of opportunities to have their views heard.

> However, select committees have never been banned from using their common sense when it comes to parliamentary procedures. The behaviour of the member for Napier over this issue for the last 3 or 4 years has pushed to the limit the patience and tolerance of anyone associated with the issue, including the select committee. There is no doubt about that. There can be no question whatsoever that the views of the people of Napier and those who represent them have been heard. They have been heard ad nauseam, month after month, year after year, and press release after press release - negative and short sighted, parochial, and political views...
>
> Just because they did not like the result does not mean the process was wrong... Parliament can be reassured that the argument that the people of Napier have not been heard is totally spurious. At the cost of millions of dollars to the New Zealand taxpayer, the view has been heard.
>
> I might finish off by paying tribute, since I have the opportunity, to the Chairman of Healthcare Hawke's Bay, Mr. Peter Wilson, and those who have worked with him over the years. That member and his local mayor have through their dogged, myopic political view made the job of getting a better public health service for the people of Hawke's Bay as difficult as it could possibly be (House of Representatives, 1997)

Initially the Wai 692 claim had focused on prevention of closure. In broadening it through the third amended statement of claim to an examination of the health reforms of the 1990s (clause 12, page 165) it provided a unique case study of the subsequent impact of those reforms on a provincial community.

# Closing Napier Hospital – a Seventeen Year Crown Decision-Making Process

The decision to close Napier Hospital, which sparked the Wai 692 claim, was not a sudden or unexpected one. The Crown and its various health entities spent a considerable period of time arriving at that decision, and involved the public of the Hawke's Bay in the decision on several occasions. There were many opportunities to involve Mäori in that process, as will be evident from the history that follows.

## The Hawke's Bay Hospital Board: A New Hospital on A New Site?

In 1980, the Hawke's Bay Hospital Board maintained three hospitals: general hospitals at Napier and Hastings, cities 18 kilometres apart, each with a range of medical specialist services and community outreach services, and a smaller hospital at Wairoa, one hour's travel time north of Napier, staffed by general practitioners.

Historically, the two acute hospitals functioned largely independently. The pressures to avoid the duplication of expensive equipment led to partial integration. The trend towards integration was assisted by the appointment of specialist staff to the Board rather than to a specific hospital, by the training programmes provided by the hospitals and by the proximity between Napier and Hastings Hospitals, a distance of only 18 kilometres.

Hawke's Bay Hospital Board undertook a major review of the future direction of hospital services in Hawke's Bay in 1980. Three main options were considered for future planning:

- further rationalisation (i.e.: reduction of duplication, services available on one site or the other) of hospital based services between Napier Hospital and Hastings Memorial Hospital.
- the transformation of either Napier or Hastings Hospital into the sole acute hospital, the other becoming a long-stay hospital.
- the establishment of an acute hospital at a new site (Shaikh, 1992, p7)

Initially, members of the Hawke's Bay Hospital Board favoured building a new hospital at a neutral location between the two cities. A site between the two cities at Clive was proposed and the cost of a new facility was estimated at fifty million dollars.

While this may have appeared sensible and appropriate, the Board members did not expect the level of criticism this proposal was to receive. The Hastings District Council was particularly strident. The Mayor stated that if a single acute hospital had to be built it must be exactly midway between the two cities. He suggested as an alternative the establishment of a separate Board to administer Hastings Hospital.

This was the start of overt action taken by both local and national politicians to protect what they believed their local communities were entitled to in the provision of health services. The Hastings Member of Parliament David Butcher, fearing that Hastings Hospital would be downgraded in favour of Napier, asked

questions in the House of the then Minister of Health George Gair about the provision of surgical services at Hastings (Shaikh, 1992).

Gradually, Hastings City Councillors and others withdrew support from the Clive proposal. The decision was then made for the Board when the Minister of Health declared that a new hospital was neither a practical nor a financially feasible plan. Instead, both hospitals received an upgrade of some facilities.

The Hospital Board resolved at its meeting in November 1980 that it would continue to maintain general acute hospitals at both Napier and Hastings, to rationalise clinical services between them, and to maintain a community hospital at Wairoa. The Board explained its reasoning for rejecting a single hospital: "Due to logistical, financial and other local factors this alternative was clearly ruled out, as an option." (Hawke's Bay Hospital Board, 1986, p232). The decision did not remove the onus on the Board to use government funding as efficiently and effectively as possible. Despite not pursuing the single acute hospital option at that time, the Board continued to consider the idea out of the public eye.

In early 1981, the Board's executive officers established the parameters for a review of the future provision of hospital-based services for the Hawke's Bay region. The Board was concerned that unnecessary duplication might further reduce their access to financial resources. The options it considered were:

- to consider the basic range of services that need to be provided in a general acute hospital at Napier and Hastings (ie services required on both sites).
- to consider the services to be provided by the Wairoa community hospital.

- to review the possibility of locating advanced services at a single institution.
- to review what clinical services might naturally be grouped together at one site (Hawke's Bay Hospital Board, 1986, p233)

The review was adopted with certain provisos at the Board meeting in May 1982. They specified both common and non-duplicated services at the Napier and Hastings Hospital sites. The review also stated what services would be provided at Wairoa Hospital.

The Board saw it as a distinct future advantage to pursue the single hospital option. "The inability to deliver health services from a single institution to a high density area has denied the Board the opportunity of 'economies of scale'" (Hawke's Bay Hospital Board, 1986, p235). The review recommended that the Board in future planning should consider rationalising its land and property holding:

- the Board hold no more (or fewer) buildings than needed for providing health care
- the building stock be located in situations best suited for populations to be served.
- the estate be used in an effective and economic manner (Hawke's Bay Hospital Board, 1986, p236)

The Board, when considering future planning issues, explored a range of scenarios. It considered the pros and cons of either Napier or Hastings as the single acute hospital site. The restricted site for future building development went against a single facility located at Napier Hospital.

The Board recognised that at some point someone would have to revisit the issues they had raised as to what was required in future health care provision for Hawke's Bay. They chose at that point not to pursue the option of a single acute hospital and defer the decision to the next group of decision-makers.

## Hawke's Bay Area Health Board – The Booz Allen Report

The new Hawke's Bay Area Health Board assumed responsibility in June 1989 for 816 hospital beds located in five different hospitals covering a geographical area of 200 kilometres. In addition to the Napier and Hastings city-based hospitals, two rural town hospitals, Wairoa and Waipukurau provided general practitioner care. Hospital services on the Chatham Islands also fell within the new Board's ambit.

By March 1990 the new Board was having to consider the single acute hospital option again. The Public Finance Act 1991 had heightened accountability, as previously noted in the section on the establishment of Area Health Boards. The issues of the level of government funding and future resource allocation meant that a single facility had to be reconsidered. At the Board meeting of 26 March 1990 the General Manager Mr. Clark, presented a report for the Board members to consider. Points he raised in his report included:

- Work needed to start quickly on the major strategic issues facing the Hawke's Bay Area Health Board, because of the impact of the New Zealand Health Charter issued by the Minister of Health and the requirement that Boards enter contracts in the form of performance-orientated accountability agreements.
- Without such work, Government funding would be constrained.
- The development of new initiatives and their application would make demands on Board finances. The Board needed to recognise that over the next five years it would face major problems of resource allocation.

Mr Clark informed Board Members that they were facing their third consecutive year of funding restraint, at a time when the public and the Government had expectations of increased activity in health promotion (Hawke's Bay Area Health Board, 26 March 1990).

He submitted that the Hawke's Bay Area Health Board was receiving sufficient funds to provide a first class acute hospital service for its communities. However, the acute service could only be afforded at one location, it could not be contemplated at two or four hospital locations.

Unless acute hospital services were concentrated at one location, all the hospitals in Hawke's Bay would provide a steadily deteriorating service. Modern acute services could be provided from one hospital, either at Hastings or Napier. The hospital not selected for long term development could undertake a reduced role in the provision of non-acute care.

Mr. Clark emphasised in his report "Acute hospital medicine requires specialist team work in a situation where all the expensive facilities of a modern hospital can be deployed to meet patient need. Acute services are inter-dependent and have to be provided on one campus" (Hawke's Bay Area Health Board, 26 March 1990, p9).

He summed up the dilemma the new Board was facing:

> It was arguable that as long as the Government was prepared to fund two acute hospitals twenty kilometres apart, nothing needs to be done. There are two major objections to this laissez-faire approach: neither hospital at present provides a comprehensive service and care for some, on occasions,

> is sub-optimal; secondly the increasing costs of health care and its new developments preclude the adoption of a static strategy (Hawke's Bay Area Health Board, 26 March 1990, p9)

The recommendations of his report were focused on pursuing the single acute service option. Mr. Clark suggested that management consultants be appointed to consider and recommend to the Board the feasibility of a single acute unit and a preferable site. The terms of reference for the study included the population projections for Hawke's Bay and appropriate services to meet the demand, determining which was the most advantageous site, either Napier or Hastings, for building development, and the cost of building development. The Board then recommended that a sub-committee be appointed to define the issues that would need to be considered by management consultants. The sub-committee would also recommend to the Board the management consultants that should be appointed to undertake the study.

In May 1990 the sub-committee informed the Board that seven proposals had been received from management consultants. The sub-committee advised they were inviting four of the consultants to make a presentation to them the following month.

In June 1990 the sub-committee advised the Board that they recommended the consultants Booz-Allen and Hamilton/Lend Lease to undertake the study of feasibility and cost of locating all acute hospital services for Hawke's Bay on one site. Objectivity and independence was what the sub-committee believed this consultancy offered.

At the Board meeting of 26 November 1990 Board members were advised by the Chairman that the public were to be excluded during the discussion of the 'Single Acute Hospital Study - Public Relations.' The grounds for the exclusion were in order to "enable the organisation to carry on negotiation (including commercial and industrial negotiation) and without prejudice or disadvantage to its commercial activities."

At the same meeting Mr. Clark advised Board members:

> that consideration had been given to the handling of the public release of the Consultants' report on the single acute hospital study. A proposed programme had been submitted by Phoenix Public Relations Ltd. of Auckland, and was presented for Members' consideration (Hawke's Bay Area Health Board, 26 November 1990, p71)

Mr. Clark outlined the advantages in engaging this organisation as the Director was an ex-Hawke's Bay person who knew the area well and was experienced in the management of public communication. The importance of this was stressed, as the public release of the Consultants' report would need to be handled correctly. Members were informed that the Consultants' report would be received 11 December 1990 and made public the following day. The meeting concluded with the Board endorsing the public relations programme provided by Phoenix Public Relations Ltd.[3]

The Public Relations Programme prepared for the Hawke's Bay Area Health Board stated its objectives as being:

---

[3] There is no record in the minutes that the Board formally adopted or agreed the public relations programme. At the 26/11/90 meeting the Board resolved that the Public Relations programme submitted by Phoenix Public Relations Ltd be received. The Board appears to have been endorsing a PR strategy selling the single site without a formal decision in principle to pursue a single site hospital.

- To inform the public in the Hawke's Bay Area Health Board region of the need and value of having one single acute hospital and increase their understanding and appreciation of the way in which it would operate.
- To communicate as effectively as possible to ensure staff were kept fully informed of developments, their rights to contribute submissions to the Board and the rationale behind the final decision.
- To ensure that the Minister together with the region's Members of Parliament and local authorities understood the reasons behind the decision and accepted that it was in the best long-term interests for the Hawke's Bay district as a whole.
- To ensure the Hawke's Bay Area Health Board was seen as having handled the investigation and subsequent decision in an open and professional manner.
- To signal to individuals and groups, both inside and outside the Hawke's Bay Area Health Board region, that the establishment of a single acute hospital (or whatever decision was taken) marked a new era in the quality of health care for the public, offered advanced prospects for staff, and provided opportunities for improved efficiency and support for community groups involved in the provision of related services (Phoenix Public Relations, 1990, p3-4)

The Public Relations Programme identified the 'target audience' and believed this was an important part of the process so that communication in selling the concept could be effectively managed. The key individuals and groups they identified were:

- staff at both hospitals at all levels in the structure,
- Board members,
- union officials,
- District Health Committees,
- Minister of Health Simon Upton and Associate Ministers,
- Director General of Health and staff,
- local Members of Parliament,
- local authorities and business groups,
- community groups,
- patients,
- and the media.

Phoenix Consultants clearly had a professional awareness of who in the community it was necessary to "manage" and bring on board. In spite of this, the Public Relations Programme presented by them had only one reference to Mäori. This is in the identified target audience collective category of District Health Committees. Iwi were not recognised or acknowledged as entitled to be informed and included in the consultation process. However, the draft timetable only considers the likelihood of presenting speeches to groups "as requested," and makes no further mention of District Health Committees or of Mäori (Phoenix Public Relations, 1990, p14-16)

Recommendations made to the Board in the Public Relations Programme were that:

> It is imperative that the Board assumes responsibility for managing all communications leading up to the release to the public of the consultants' report and the processes whereby the public can present submissions before Board members make their final submissions.
>
> All methods of communication must be carefully coordinated to ensure consistency of message and be designed to generate maximum support throughout the community - including the media (Phoenix Public Relations, 1990, p7)

The strategy in selling the message to the defined target audience groupings varied considerably depending on how significant they were perceived to be by the public relations consultants. There were contrasts in how the different groups would be managed. Union officials would receive all written information provided to staff and a personal briefing. In comparison, specialist staff would receive all staff communications, a special group briefing, a copy of the executive summary, and the full report. Members of Parliament were invited to a special

briefing by the consultants, and given a copy of the report and executive summary and a letter from the Chairman of the Board detailing action over the decision process.

Local groups and community activists were to receive a letter from the Chairman explaining the process for submissions, a pamphlet would be enclosed and an offer made to speak to the group to explain the decision. For the public the primary means of communication was to be paid advertising in the local paper, supplemented with editorial publicity and columns and letters to the editor.[4] A brochure was to be sent out to households.

The release of information to the public was to be managed so that key issues could be developed. The consultants recommended that certain points be emphasised to enhance public support. These points included the provision of healthcare services to the Hawke's Bay, how these would be improved and a suggested follow-up to the programme one year on to demonstrate the benefit of the decision. The management of the public release of information extended to the media: "Phoenix will liaise with the key media to arrange/interest in editorial coverage" (Phoenix Public Relations, 1990, p9).

The report was timetabled for release to the public at a press conference 12 December 1990. There was to be local media coverage, presentations, letters and brochures to identified key groups. Ten weeks had been allocated for consultation.

---

[4] While it is clear that Phoenix Public Relations intended to mount a letter-writing campaign, it is unclear from their proposal whether they would prepare the letters for such a campaign or encourage members of the public to do so.

The Board invited the public to express their opinion either in written or verbal submissions before the Board made a final decision. The public submission days were advertised as 20 and 21 February 1991. It was anticipated that the Board would make a final decision by the first week of March.

The Booz-Allen Hamilton Lendlease Corporation Report was released to the public on 12 December 1990. The study had taken 23 weeks and followed extensive consultation with staff, councils, unions and the media. The consultant's recommendations were:

- That a single acute hospital facility is developed on the site of the present Hastings Hospital over the next four years.
- That all low risk obstetric services should be located at the Hastings Hospital site.
- That all children should be located together in a children's unit at Hastings.
- That Napier should retain clinics and long stay geriatric facilities, probably located in town, closer to the community.
- That policies on personnel matters should be developed by the Area Health Board whilst planning proceeds (Booz Allen and Hamilton, 1990, Summary)

The last two recommendations clearly imply the closure of Napier Hospital as a consideration. Without the ability to interview relevant executive staff, it has not proved possible to determine to what extent that implication was a factor in the Board support of the recommendations.

The consultants provided supporting information detailing how they reached their recommendations. They had considered demographic trends and projected growth for Hawke's Bay, transportation and accessibility, socio-economic factors, capital

costs, land and building value and most desirable planning solution. Hastings was preferred as:

> [the] site is flat and would allow greater flexibility to position the recommended low-rise buildings efficiently. This means that specialist wards could be located close to clinical support services. Access and parking for each sector of the hospital could be provided as necessary and clearly identified. The design and layout would allow efficient movement of staff and patients, and the site would be able to accommodate future change (Hawke's Bay Area Health Board, 1990, p4)

The study concluded that the Hastings site would be less costly to develop than Napier; it would take less development time, ongoing maintenance costs would be reduced and all specialist services could be located on the one site saving a suggested one million dollars a year.

Also in Hastings' favour were the population projections to 2006. While the population was split evenly in 1990, it was projected that Hastings would grow faster and Napier would age faster. Hastings, it was felt, had better road access and public transport with a better chance of obtaining a helicopter licence. Hastings provided more flexibility for future changes and overall was a better planning option. The suggested cost for the single acute hospital development at Hastings ranged between sixty-six and seventy million dollars. In the information to the public the initial cost was to be balanced against the proposed savings, an estimate of between $7.4 and $8.6 million with the consolidation of all acute services onto one site.

The Napier City Council described the report and its associated marketing in the following terms:

> This recommendation, its associated sales promotion and consultation, started the controversy, conflict and anxiety which has continued since

> unabated. No issue has ever created such polarisation and divergence of views across Hawke's Bay (Napier City Council, 1996, p1)

Opinion varied as to whether the proposal had merit or not. Difference of opinion was not limited to the local critics. There were mixed points of view from Parliament. The change of government in 1990 meant a new Minister of Health. The commissioning of the Booz-Allen Report was to some extent in response to the previous Minister of Health Helen Clark's stated expectations. Now there was uncertainty as to what the new Minister, Simon Upton, would expect and support.

The Area Health Board minutes indicate that at their meeting of 28 January 1991 the Board had received correspondence from the new Minister dated 13 December 1990 indicating that he was not offering unreserved support for the Booz-Allen Report. The Minister stated:

> Thank you for your offer to discuss this with me but at this stage my preference would be to await a further report, via the Department, on the progress of Board/Community consultation and the likely outcome which would result. This, together with particular operational or financial information will enable me to convey to the Board, before it makes any decision, any matters I might consider relevant. Hawke's Bay Area Health Board, 13 December 1990, E)

Some members of the Board felt it was necessary to "seek an assurance from the Minister that the Board's long-term plans, once developed, would not be frustrated by any change in Government policy."[5] (Hawke's Bay Area Health Board, 28 January 1991,p 231). The minutes do not indicate whether this was pursued. The new tone must have created a dilemma for the Board. They were now embarked upon a process that they could not easily disengage from. They not only had a

---

[5] Board Members or executive staff might have been able to throw some light on whether this assurance was pursued, either formally or informally. Unfortunately, Healthcare Hawke's Bay declined to allow interviews of either Board members or staff.

community consultation process under way; they had also invested $600,000 in the report.

At the same meeting the Phoenix Consultancy were invited to inform the Board of their recommendations for the next phase of the public relations exercise. The feedback was described as generally being in favour of the Board but more education and information on the issues was required.

It was suggested that the Board consider a shop front display in Napier City as this would provide improved access to the information for a wider range of people. Written information and models would be displayed to try and provide a visual example of the proposed concept. The Board supported this. The shop front display was open in Napier for three weeks and then moved to a similar venue in Hastings.

Phoenix made further suggestions on the management of the information and how it would be received by the public and relevant decision-makers. At the Board meeting on 28 January 1991, their Director gave the following advice:

> Mrs. Langley pointed out that it was likely the Board would receive a higher proportion of submissions against the recommendations than in support of the proposal, and she suggested it could be useful for the Board to undertake some research with a view to obtaining a regional perspective on which to base its decision. She also suggested that tours of the two hospitals could be organised for the local MPs, Mayors, Council Officials, and news media editors, to enable them to obtain a geographical insight into the recommendations (Hawke's Bay Area Health Board Minutes, 28 January 1991, p 232).

It had also become clear that the proposed schedule for submissions, feedback and management of the information process would have to be extended. A motion was

passed extending the period for submissions by one month. A special Board meeting was set for 11 April 1991 to consider the recommendations in the Booz-Allen Hamilton Report and make a decision.

The Board minutes of 25 March 1991 comment on the high quality of the submissions, both written and verbal, on the single acute hospital proposal. It was also timely that the Minister of Health was to meet with the Board Chairman and General Manager in Wellington one week before the special meeting of 11 April.

Minutes for the meetings held on 11 April (the special meeting) and 29 April 1991, where it is likely that any formal decision concerning the Booz Allen report was made, have not been supplied to the commissioned researcher.[6] All indications, such as the confirming of minutes at the May 1991 meeting, are that one or both such meetings were held.

The Board had been alerted to the Minister's concerns about the Booz-Allen proposal in December 1990. By 12 April 1991 his criticisms were more explicit and focused on the increased debt loading for the Board if they took on the additional costs that regionalisation would incur. The Minister of Health expressed his concerns:

> The level of additional debt envisaged is much higher than originally anticipated. Although it may be possible for the board to sustain this level of debt any significant changes in terms of interest rates, cost increases or projected savings to be achieved would make this difficult. As well, placing the board in a high debt situation reduces the flexibility it will need over the short to medium term.

---

[6]The author requested all of the Healthcare Hawke's Bay Board minutes from 26 March 1990 to mid 1999, a period that would include Area Health Board minutes. Most AHB minutes have been supplied but it would appear not all.

> Given the high level of debt required to finance the recommendations I wonder whether sufficient benefits are being obtained. Although the ideal situation recommended by the consultants would meet quality concerns regarding acute services the cost as it stands is probably too high (Hawke's Bay Area Health Board Minutes, 227 May 1991, M1)

The Minister suggested that the Board undertake further work investigating options that could accommodate the concerns he raised. One of the suggestions he made for further exploration was to:

> assess whether an "intermediate" option is available which would require significantly less debt raising but would enable critical service quality gains to be made. Such an option might, for example, place acute surgical services on one site with non-acute services such as long stay and some convalescence being located at the other site.

One member of the Board expressed concern that if the Minister's letter was publicly released "it would identify to the community that their concerns were not parochial issues but were concerns shared by Government" (Hawke's Bay Area Health Board Minutes, 27 May 1991, p 273). Another felt that it was better that the letter went on the record, as it was better to inform the public of these matters.

It is unclear whether the Minister's suggestions were pursued at this time as the Board was disbanded on 30 July. Given the lack of relevant minutes for April 1991, it is impossible to conclude whether the Board formally adopted the Booz-Allen report and recommendations, or, given the Minister of Health's interest as evidenced in his letter of 12 April 1991, deferred a decision until they were disbanded. Interviews with staff or Board members could have quickly clarified this point, had they been allowed.

As an interim arrangement, in the transition to a funder/provider (RHA/CHE) split, the government replaced Area Health Boards, including the Hawke's Bay

Area Health Board, with Commissioners. Little can be reported about decisions made during the tenure of the Commissioner, Andy Train, the previous Chairman of the Area Health Board.[7] Community disquiet is evidenced by letters from Michael Laws MP to Simon Upton, the Minister of Health and Paul East, Minister of Crown Health Enterprises, stating that the Napier community would not be happy if Andy Train was appointed to chair the new Crown Health Enterprise, when it was formed:

> Mr. Andy Train was then appointed by you as the new Health Commissioner for Hawke's Bay – a man who championed the Booz-Allen report when he was the chair of the Hawke's Bay Area Health Board.
>
> The controversy was further stirred when Sir Ron Trotter and Mr. Harold Titter made a flying visit to Hawke's Bay – in their capacity as your appointees, and made the precipitate remarks that Hastings was the logical site for a single acute hospital (Laws, 1992)

Harold Titter was Andy Train's equivalent, as Commissioner for the Auckland Area Health Board. Sir Ron Trotter was the Chair of the National Interim Provider Board, the body overseeing the transition from Area Health Boards to Crown Health Enterprises.

## Healthcare Hawke's Bay - Layers of Accountability

Two key questions related to the Crown responsibility under the Treaty of Waitangi arise in considering the Healthcare Hawke's Bay decision early in the 1990s to site a single regional acute hospital at Hastings. The two questions are:

- When was the decision made to have a single regional acute hospital?
- When was the decision made to site the single acute hospital in Hastings?

---

[7] Because the researcher had been refused access to interview staff in respect of the intervening period by Healthcare Hawke's Bay, Crown Law letter to Lisa Ferguson, 18 February 1999

These decisions and the manner of their making are critical in determining whether the Crown breached its duty under the Treaty of Waitangi. The decisions are considered in each of the next two sections, entitled Regionalisation and the Hastings site. The implementation of the decisions is considered in the following section.

### *Regionalisation*

The Board of Healthcare Hawke's Bay (or Crown Health Hawke's Bay Limited as it was called when first created) has always made the commercial or business decisions. The Board is accountable to the Shareholding Ministers. The Board's performance is monitored by the Crown Company Monitoring Advisory Unit to ensure that fiscal risk is minimised and that sound commercial decisions are made. The senior executive team is responsible for the operational day to day running of the hospital and reports to the Board through the Chief Executive Officer.

To the public it may appear that there is a reasonable distance between politicians and the management decisions taken by the senior executive staff in running a hospital. Yet Simon Upton the Minister of Health (1991) took an active interest in the planning of health services in Hawke's Bay during Area Health Board tenure. This intimate involvement by Ministers in decisions at the local level did not end with the change to CHEs(1993). The Minister had already expressed concern at debt levels likely to be incurred by a single acute hospital plan.

Writing to a Napier citizen on 28 June 1994, Paul East, Minister for Crown Health Enterprises, explained what had become of the Hawke's Bay Area Health Board $16 million reserve fund.

> In recognising the reserve shareholding Ministers were mindful that the Hawke's Bay Area Health Board had established the reserve to assist in funding the consolidation of the existing services onto one site. The reserve was agreed to on the basis that the Board of Healthcare Hawke's Bay undertake a full business appraisal of the issues surrounding the initiatives advanced by their predecessor organisation. Having completed the appraisal and obtained support and commitment from the purchaser of health services, Shareholding Ministers undertook to make funding available, with the exact detail of the funding being determined at that time.
>
> In recognising the reserve and in keeping with the approach taken with other Area Health Boards, it was the intention of the shareholder to relate the reserve to a particular event. That is, if the proposal for the review of health services in Hawke's Bay had not been active at the time, the reserve would not have been established. By implication therefore, had there been a continuation of the status quo, the reserve would not have been created at the time Healthcare Hawke's Bay was established (Gwynn, 6 April 1999).

Healthcare Hawke's Bay needed to review health services again if they wished to receive the $16 million held by their predecessor organisation. This was a substantial amount of money hanging in the balance. Regionalisation was on the agenda again in part because of a desire on the part of Healthcare Hawke's Bay to retain the reserve fund.

The Funding Agreement 1 July 1993 between Healthcare Hawke's Bay and the Ministers of Finance and Crown Health Enterprises established that the $16 million was to be paid to Healthcare Hawke's Bay on 31 December 1994 or earlier if Healthcare Hawke's Bay was commercially at risk. Clearly, as the Minister indicated, the government had been satisfied that Healthcare Hawke's Bay had met its preconditions for release of the reserve fund at July 1993.

The Board minutes from June 1993 comment on the discussions with the Crown Health Enterprise Management Unit, the predecessor of CCMAU, on the business plan. The minutes indicate that the pressure to act on regionalisation at times was driven by Treasury officials. "Management of the $16 million reserve fund was resolved and it was recognised that consolidation of the acute hospital issue had to be addressed quickly" (Hawke's Bay Area Health Board Minutes, 29 June 1993).

> Healthcare Hawke's Bay has been defensive in the past when critics within the Napier community have raised the issue of predetermination. The critics have argued that the decision to regionalise the health services in Hawke's Bay was made well before public consultation took place (Hawke's Bay Area Health Board Minutes, 29 June 1993).

It is evident that the decision to regionalise the services was made before or during the first half of 1993. This was well before public consultation, which did not commence until 1994. The 1993 Statement of Intent from Healthcare Hawke's Bay, presented to Parliament in August 1993, states:

> Healthcare Hawke's Bay is to conduct a review of the provision of hospital services in Napier and Hastings. It is intended to develop a regional acute facility on one of the current hospital sites. A decision as to the site will be made by February 1994, and rationalisation of services will then proceed.

This issue is a pivotal one. It is impossible to say with any certainty what the exact timing of the decision was. The Commissioner, Andy Train, could have made it without reference to any committee. The CHE Board designate could have made it before taking up office. The author of the Statement of Intent could have made it in isolation. The decision by Healthcare Hawke's Bay to refuse interviews of its staff and Board members has meant that the transition period between the Area Health Board and the CHE is largely devoid of information.

It is apparent that the status quo was never in contention. The title of the consultation project following the Taskforce report, "Public Consultation on A Regional Hospital for Hawke's Bay" makes this quite clear. The report was clearly designed to set public expectations for a change.

### *The Hastings Site*

At the first meeting of the CHE Board proper (as opposed to the CHE Board designate) on 19 July 1993, members were advised during an address by the Chair that a single acute taskforce had been established. The members consisted of Mark Flowers, Surgical Services Manager (Chair), the Chief Executive Officer Alistair Bowes and the Finance Manager Paul Drury.

The first key issue to be examined by the Taskforce was stated as:

> The establishment of a vision... The vision should be established to the exclusion of the various interest groups, to provide the Board with an ultimate long-term goal[8] (Hawke's Bay Area Health Board Minutes, 19 July 1993).

At the Board meeting of 23 August 1993, a proposed methodology for the planning of the regional hospital was considered. A design model based on identified parameters would be developed, against which to test the Napier and Hastings sites. Mr. Wilson, Board Member[9], made the following statement about the decision making process:

> He believed the Board should first reach its decision and that once a decision has been made, it would then need to market the idea very carefully. He considered it was important that no public debate should be

---

[8] On the face of it, this issue suggests that the Board were adopting an approach of intentionally limiting public debate. While this may not have been their intent, without the ability to interview staff or Board members, the researcher is unable to clarify this point.

[9] There were two Board members named Wilson, the Chair, Peter Wilson, and Walter Wilson, the Māori Board member from Wairoa. At times in the minutes it is difficult to determine with certainty which Board member is being referred to.

> entered into on this decision until the Board had made its decision (Healthcare Hawke's Bay Board Minutes, 23 August, 1993, item 16)

The Model Regional Hospital paper of November 1993 provided a working example of the model regional hospital that it described as a facility designed from the ground up.

> For over three months the task force and staff have worked on an ideal hospital design. This was an essential requirement before we examined the Napier and Hastings sites and then quantify the costs of getting them as close as possible to this ideal.

The team planned to evaluate how Napier and Hastings Hospitals could be adapted to get as close as possible to the model hospital design. It is unclear in the paper how close the "model hospital proposal" was to the Booz-Allen recommendations or whether this was a reworking of the Minister's suggestion for an intermediate option.

There were similarities to the Booz-Allen report terms of reference. One wonders why a new set of consultants (Octa Associates, Project Managers) was brought in to rework the original recommendation that had cost $600,000. It is unclear why they were reconsidering both sites again when they had been provided with an expert opinion as to the most cost-effective option in 1990.

The Healthcare Hawke's Bay document entitled 'Analysis of Potential Efficiencies' indicates that in November 1993 Service Managers for Healthcare Hawke's Bay were asked to explore the possibilities for saving 4.5% per annum from operating budgets without significantly reducing outputs. The suggestions included the frequently raised option of a regionalised hospital service. It was believed that efficiencies could be gained in the following areas: Immediate

Efficiencies (Service and Staffing), Regional Hospital Development and Information Systems Development.

In a 23 December 1993 memorandum to senior staff from Mark Flowers, Surgical Services Manager (and Taskforce member), it was evident that the regional hospital proposal had progressed to discussing bed requirements and working within a specific time frame. Consultants were identified to work with management on the proposal.

> Also attached is a chart of bed requirements for the proposed regional hospital. The aim is to "sign off" with you and clinical staff on the bed and staff requirements by the end of January. We will also want to confirm staff savings by that time.
>
> We are also working on space requirements for departments and the like. These will be discussed with you during January, and will involve Colin Clayton from OCTA Associates who are assisting with the design of the hospital (Healthcare Hawke's Bay, Model Regional Hospital paper, 1993).

In the detailed analysis of the Regional Hospital Development there was an emphasis on projected savings that were assumed to be available in 1995/96. The benefits were summarised as quality, medical/legal, financial and certainty. Issues around patient care were raised in support of regionalisation. It was believed that the centralisation of services would enhance patient care.

The Taskforce continued working on the proposal and presented a report to the Board of Healthcare Hawke's Bay March 1994. The Task Force had considered three scenarios: to locate all acute services at either Napier or Hastings, or to maintain the status quo. Included in the terms of reference was "minimising damage and loss to the site not chosen" (Regional Hospital Taskforce, 1994, p23).

The Taskforce report's options were similar to those studied by consultants in 1990. The recommendations and conclusions of both groups were also similar. The Taskforce's recommendation was that a regional hospital be developed on the site of the Hastings Memorial Hospital.

The Taskforce recommended Hastings as the preferable site, giving four main reasons:

- the site is central to the region.
- the site has easy access, is well laid out and provides the greatest flexibility for future developments.
- the site is safe from flood and all buildings can be constructed or upgraded to withstand a major earthquake.
- development costs are lowest and provide the best rate of return (Regional Hospital Taskforce, 1994).

It also recommended that a substantial part of Napier Hospital be retained for certain categories of patient care including a range of day and outpatient services and community health and disability services.

The Board at their meeting of 29 March 1994 received the report in draft.

The Healthcare Hawke's Bay Board made their final decision at their meeting of 21 July 1994. The Hastings site, as recommended by the Taskforce, was adopted as the site of the Regional Acute Hospital. In arriving at its decision, the Board considered the Taskforce report in the light of twelve different questions. These included issues of scale in servicing a total population of 140,000, purchaser's requirements for access, and employees' points of view. No reference was made in the Board's decision-making criteria to the needs or wants of any particular

community segment, including Mäori. The impact, if any, of the one Mäori Board member on the decision is covered in the section on representation later in this chapter.

The Napier City Council challenged the consultation process and pursued a case in the High Court in November 1994. The City felt that the limited amount of time for consultation prevented them from making a considered submission. They also alleged non-disclosure of information and asserted that the Board was biased and that the decision was predetermined.

In his judgement, delivered on 15 December 1994, Judge Ellis directed that the City enter into further consultation with Healthcare Hawke's Bay and that they receive further submissions from the City. The City was allowed further time to prepare and make those submissions. Napier City Council presented a fresh submission in February 1995. Despite the efforts and cost to the City, they were unable to alter the outcome.

On 28 March 1995 the Board of Directors of Healthcare Hawke's Bay confirmed their decision that:

> Hastings Memorial Hospital is reconfigured to become the Hawke's Bay Regional Hospital, providing the current range of services available across the two sites in Hastings and Napier, and
>
> Napier Hospital is reconfigured to provide a comprehensive range of outpatient, accident and medical services, continuing and day care for the elderly, Mäori health facilities, maternity care, day surgery, and as a base for community care services for the Napier area (Healthcare Hawke's Bay, Collection of Information, 1995)

The last question raised at the beginning of this section, that of Mäori participation in the decision-making process, is covered in detail in the section of this chapter entitled "Crown Compliance with the Treaty of Waitangi: the core of Wai 692" on page 202.

### *Implementing the decision*

At the conclusion of the above Board decision, the Board advised that it would be developing an implementation framework for the Regional Hospital project. They stated that their intention was that the implementation programme would involve members of staff, the Hawke's Bay Health Council, who would represent the Local Authorities, GPs, and other unidentified health stakeholders.

The Board reminded the community that the Central Regional Health Authority, rather than the Board, was responsible for consultation with the community. In doing so, they relied on the Health and Disability Act 1993, which requires funding bodies to consult, but does not specify the same requirement on providers. However, the decision of Judge Ellis, in the Napier City Council challenge to the Healthcare Hawke's Bay decision, made it plain that the CHE also had a requirement to consult, as a State Owned Enterprise. Central RHA had to incorporate community opinions in their purchasing decisions for the health care for the people of Hawke's Bay. Healthcare Hawke's Bay was subsequently contracted to provide the services stipulated. Healthcare Hawke's Bay stated they would endeavour to work with the community "to ensure that the services that we are contracted to provide are delivered in the most favourable way for the region" (Healthcare Hawke's Bay; Decision of the Board, 1995).

This attempt at clarification does sound a little like Healthcare Hawke's Bay placing the responsibility for the change at the door of the Central Regional Health Authority. It also avoids the fact that regionalisation had been repeatedly explored by the successive Boards of the region, Hospital, Area Health Board, Commissioner, and Crown Health Enterprise. Furthermore, the advice the Board had received from their consultants when considering the public relations programme was:

> That for the Company to be a successful commercial organisation it was necessary to have the co-operation of its stakeholders, the public. The process he was proposing was in effect a stakeholder consultation process (He) suggested it would be appropriate to approach the RHA and seek their support and involvement in a joint venture approach (Healthcare Hawke's Bay Board, 29 March 1994).

This is not to say that a close relationship did not already exist between the two entities. The discussion document released by Central Regional Health Authority in August 1994 outlined their purchasing expectations for Hawke's Bay. It fitted neatly with the Taskforce recommendations and the Board's just approved reconfiguration of services.

> The Board of Directors of Healthcare Hawke's Bay has recommended a regional hospital at Hastings and a range of services to be provided from Napier Hospital as a complementary site. The Central RHA has assessed the Board of Healthcare Hawke's Bay's recommendations against the criteria of quality, access and value and has accepted that a regional hospital at Hastings, with complementary services being provided at Napier Hospital, fits with its purchasing expectations (CRHA, 1994).

Healthcare Hawke's Bay had been at some pains to ensure that the Central RHA was well briefed on their plans, releasing a draft copy of the Taskforce report to them at the same time the Board received it. Board discussion made plain that they regarded purchaser approval of their proposal as critical, even if there was no formal requirement to obtain such approval (Healthcare Hawke's Bay Board Minutes, 29 March 1994)

The services that the Central Regional Health Authority expected to purchase from the Napier Hospital site were:

- Accident and Medical Services (within business hours 9am- 5pm)
- Maternity Services
- Outpatient Services
- Day Surgery
- Dental Services
- Care of the Elderly Services
- Continuing/Terminal Care Services
- Community Health Services
- Mental Health Services
- Services for people with disabilities
- Alcohol and Drug Services
- Sexual Health Services
- Public Health Services
- Child Health Services
- Mäori Health Services

The Central RHA expected that those services would require the provision of at least the following support services:

- Pharmacy Services
- Pathology Services
- Radiological Services

Acute services, including acute surgical, medical, and 24 hour accident and emergency services were no longer to be purchased and provided from the Napier site (CRHA, 1994).

The part the Central Regional Health Authority had played in the decision to regionalise has not been highlighted to any great extent in this research. This reflects a combination of factors impacting on the research. The difficulty accessing many of the Healthcare Hawke's Bay documents, together with the refusal on the part of the Health Funding Authority (which assumed the role of the Central RHA in the 1996 reform) to allow interviews of their staff, has meant that the relevant documents to support or record the Central RHA decision-making have not been able to be identified.

The purchasing expectations of the Central Regional Health Authority reassured the community that they would not lose the hospital (CRHA, 1994). While not overjoyed that they would not retain 100% of the services that the hospital had provided, public opinion in Napier was somewhat appeased that something would be retained. As a result of this, there was a slight lull in community action to resist the changes they believed were attributable to health reform. While not completely satisfied with what was proposed, they had some reason to believe that the remaining services delivered from the Napier Hospital site were safe (Waitangi Tribunal, 2001).

The next phase in the regionalisation proposal was the implementation framework, which was going to make the proposal a reality. A steering committee was established and Mark Flowers, now Development and Planning Manager, was appointed to oversee the project. The steering committee consisted of executive and clinical staff. Octa Associates were appointed by the Board to carry out the project management of the construction of the Regional Hospital and

associated works. The date for the presentation of the final plan of the Regional Hospital was December 1995. The projected date for the completion of the Regional Hospital was May 1998.

The regional community was subjected to another round of consultation and public relations. Those in the community with an interest in health care were to be known as "stakeholders" following the advice of Network Communications to Healthcare Hawke's Bay (Henley, 1994). They were targeted in the project goals of the implementation plan so as to "implement the appropriate involvement of the broader community and health interest groups to achieve a sense of community ownership" (Healthcare Hawke's Bay, Implementation Framework, 1995, p 2.)

The community may have been reassured by the purchasing commitment from the Central Regional Health Authority. However, the business plan of Healthcare Hawke's Bay approved by the Government by June 1995 indicated how additional savings could be made " from the decision to move to a single regional hospital, instead of maintaining two hospitals in Napier and Hastings" (Gwynn, 1995, p2). While assurances may have been given publicly Healthcare Hawke's Bay was informing the government of the cost effectiveness of what they intended to pursue.

The publication in 1996 of the Central Regional Health Authority's purchasing expectations 'Health Care in Napier' alerted the public that changes were occurring that contradicted what they had committed themselves to in 1994:

> Central RHA has decided not to specify where services should be delivered from in Napier. We are aware of the strength of public commitment to the Napier hospital site, and appreciate that leaving the location of services undetermined is a significant change from what was in the 1994 document.
>
> It is not the Central Regional Health Authority's role to specify the site from which providers will operate. Central RHA is responsible for a range of functions, including monitoring health, assessing the need for health services, and purchasing those services. As such, we can only specify the levels of services that will be purchased, quality standards that providers must meet, and criteria that determine who needs to have easy access.
>
> Central RHA cannot specify the site services should be provided from, as this would mean limiting who could provide the service. Specifying the site would also significantly limit a provider's ability to be innovative and improve services. It could also be seen as anti-competitive and in breach of the Commerce Act (Central RHA, 1996, p 5)

It has not been possible for the researcher to establish what influenced the CRHA to shift its position, for lack of access to official information. However, this change, the dropping of a commitment to the location of hospital-based services for Napier, was a critical step towards the eventual fate of Napier Hospital. The Central Regional Health Authority proceeded to acknowledge that Healthcare Hawke's Bay would need to take into consideration public opinion regarding the Napier hospital site. The Central Regional Health Authority wanted to reassure the people of Napier they would not lose services, even though the site for those services would not be specified:

> The purchasing expectations state that while the Central Regional Health Authority cannot be site specific for clinical safety certain services need to be located within close proximity of each other. These were identified as accident and medical, day surgery, and medical and surgical outpatient (Central RHA, 1996, p 5).

This now provided the opportunity for Healthcare Hawke's Bay to contain all services on one site. Whenever the various Boards had considered the single facility option, their ideal from the early 1980s had been to contain all hospital services on one site.

The further loss of services from Napier Hospital was not well received by the people of Napier. For some in the community it felt like a betrayal of what they had been promised. They believed that the intention of Healthcare Hawke's Bay had always been the closure of Napier Hospital and that this had been assisted by the position Central Regional Health Authority had taken in their 1996 paper Health Care in Napier. The Board Minutes of meetings following the final decision on the regional hospital in March 1995 provide some indication of the parties influencing the decision to exit the Napier Hospital site.

### *Working towards closure*

Following the CRHA declaring its position on the Napier site, in March 1997 a working party comprising Healthcare Hawke's Bay staff and representatives from the community selected by Healthcare Hawke's Bay was brought together. There was no specific representation of Mäori interests on the working party. The working party examined and recommended to Healthcare Hawke's Bay the scope and volume of services that it considered appropriate for the Napier community. The Central RHA document was to be the basis for the initial discussions. Healthcare Hawke's Bay consistently dialogued with Central RHA to ensure that any developments they initiated matched the purchasing intentions of CRHA.

Two key issues were to be addressed by the Napier Services working party: building site configuration, and volume of service. The terms of reference for the working party suggest that future services for Napier were to be delivered from a new site and not the Napier Hospital site:

- To determine service and building configuration options for delivery of those services.

- To consider site options for delivery of those services within the city and ensure the recommended site(s) meet configuration, access and cost requirements.
- To make recommendations to the Executive of Healthcare Hawke's Bay on the preferred option(s).

The working party spent four months investigating various options for the location of Napier's future health services. The report they produced in November 1997 made three main recommendations:

- That a new purpose-built health centre be located in the central city.
- That certain services are co-located [within close proximity of support services, suggesting on the one site]. These services include outpatients, an accident and medical centre, therapy services, support services including x-ray and diagnostic services, dental services and day surgery performed under local anaesthetic.
- That other services are provided from one or more separate downtown sites. Many of these services are already established downtown (Healthcare Hawke's Bay Media Release , 3 November 1997).

The recommendations also included in the report to the Executive of Healthcare Hawke's Bay were quite explicit about the siting of services for Napier: "Clinical services for Napier should be provided from a new built facility in a City centre location, not on the hill."

A pamphlet was distributed in November 1997 to all households in Napier and Taradale outlining what the working party had recommended. Public meetings were to be held and were advertised widely. The public had five weeks until 5 December 1997 to make written submissions.

For the people of Napier there was a familiar tone to the way the information was being presented for the public. The recommendations were of little surprise and there was a sense of inevitability in the outcome. Effectively the Napier Hospital site was to be exited by Healthcare Hawke's Bay.

Like previous information management exercises , the public were to be consulted with the decision already made, and were informed they would have little influence on the outcome. The process was a public relations and marketing exercise, rather than anything approaching the consultation and partnership in decision-making implied in the Treaty of Waitangi. As with the previous public consultations of 1994 the status quo was not up for consideration, despite it being called consultation. A participant has described it as "telling us what was going to happen" (Joe, Interview,1998). The 28 October 1997 Board minutes indicate that consultation was to proceed on the understanding that it was focused on a new site for Napier services: "The Minister of Health's office had agreed that the Company could proceed with consultation on the Napier site issue, on the basis of a downtown site."[10] (Healthcare Hawke's Bay Ltd. Board, 28 October 1997, p17)

The Chairman of the Healthcare Hawke's Bay Board commented in a press statement on 3 November 1997:

> The Board is charged with making the final decision on the location of health services in Napier, but before we make that important decision, we

---

[10] Note that the reading of the Board's minutes is subject to interpretation, as there is an ambiguity over whether the Minister assented to the downtown site, or required the downtown site. This key difference of perspective could not be resolved from the minutes alone. An interview with relevant Board members may have helped to resolve the ambiguity. Such interviews were denied. An interview with CCMAU that allowed discussion on the Napier Hospital claim may also have resolved this issue. Once again, an interview on that basis was not allowed.

> want to know what Napier people think about the working party recommendations.
>
> The primary purpose of this consultation is to gain feedback from the community on the principle of a new purpose-built health centre located in downtown Napier (Healthcare Hawke's Bay Media Release , 3 November 1997).

The working party report included a timetable for the new Napier site development in the central city. The new facility was expected to be completed at the end of 1998.

However, the Board minutes of 28 October 1997 indicate that the Board was investigating options and creating a community expectation when funding issues had not been resolved:

> The Chairman stated Treasury now required a business case to be prepared specifically for Napier before they would make any recommendations to the Shareholders. He also pointed out that Central Health were not prepared to pay a service delivery premium in recognition of increased costs as a result of duplicating facilities in Napier. This would impact on the Company's financial position to the extent of $0.95 million.
>
> The Chairman advised that some funding options had been presented to the Shareholders to ascertain their preference for funding this project. Treasury and Central Health had since indicated that the Company's business plan assumptions in terms of efficient prices, compensation for inflation of supplies and increased wage costs would not be renumerated. In other words, there would be no increased revenue flows (Healthcare Hawke's Bay Board, 28 October 1997, p 17)

The Board minutes of 25 November 1997 indicate that the funding issue was resolved.

> The Chief Executive Officer stated that advice had just been received from Andrew Weekes of CCMAU, that the Minister of Health had agreed to sign their letter and would be releasing a press statement later that day advising of Government's additional equity investment in Healthcare Hawke's Bay ( Healthcare Hawke's Bay Board, 25 November 1997, p 5)

At the 16 December 1997 Board meeting the Board unanimously agreed that the Napier Hospital site should be vacated in favour of a new health centre to be located on a site in Napier which meets certain specific requirements. It resolved:

> That the specific requirements are that the services to be provided in Napier by Healthcare Hawke's Bay are provided from a downtown site and that the site be of sufficient size to allow the potential for the transfer of Community and Public Health services on the site, and be of sufficient area, both in terms of building development and parking, to allow for co-location with other providers on the site.
>
> That this is a decision in principle and that its implementation will be dependant on a suitable site being located, and on terms and conditions for the development of the site and its lease by Healthcare Hawke's Bay meeting the Company's requirements (Healthcare Hawke's Bay Board, 16 December 1997, p20)

A timetable for the relocation of those services based at the Napier Hospital site to Hastings was to be implemented from December 1997. The complete exit from the Napier Hospital site, except for the Company office, was scheduled to be completed by July 1998. This was later postponed until October 1998.

The new regional Hawke's Bay Hospital was formally opened in April 1999. The Napier Health Centre was completed by December 1999.

## Crown Compliance with the Treaty of Waitangi: the core of Wai 692

Clarity on the timing and implementation of the decisions to regionalise and site services at Hastings hospital is an important precursor to determining the answer to the key question:

- What opportunity was afforded to Iwi Mäori to participate in and inform either of these decisions?

The when and how of the decisions considered above provides an opportunity to evaluate the impact of Mäori on that decision-making. Healthcare Hawke's Bay was but one part of the Crown involved in those decisions. This section considers the extent to which Healthcare Hawke's Bay is accountable for those decisions. Each of the Treaty principles, consultation, participation, and representation, are then used in turn to determine Healthcare Hawke's Bay's compliance with the Treaty of Waitangi in the way it reached its decision to site a regional hospital at Hastings, and thereby downgrade and ultimately close Napier Hospital.

## Accountability

While it may at first sight appear that the health reform process has hindered the process of regionalisation of the Hawke's Bay hospitals, such an interpretation is not, in my view sustainable. The health service framework existing in 1991, with democratically elected Area Health Boards, meant a 3 year election cycle, plus representatives who were highly sensitive to local considerations. As has been shown, the Hawke's Bay Area Health Board had great difficulty making a decision on the Booz-Allen report, and received direct ministerial input on at least two occasions into that decision. It is unlikely, in my view, that a continuation of that framework would have led to a decision on the regional hospital option at a much greater speed than the Crown Health Enterprise model achieved.

It is noteworthy that throughout the CHE deliberations on the regional acute hospital service and the future of Napier Hospital, many bodies have influence, and the pattern of decision-making is quite complex and unclear. The latter may partially reflect the limited access to documents and staff that have constrained

the author in her researching. However, it may equally well reflect an environment where public accountability through democratic representation in the governance of district health agencies had been removed, and the bodies making decisions did so in an executive, rather than a committee style.

A purchaser wishing to pay the most economic price for a service, together with a provider trying to minimise their debt loading, may easily lead to a situation where selling an asset that is not wanted (Napier Hospital) and replacing it with new leased premises, is seen as commercially beneficial on all sides (Healthcare Hawke's Bay Board, 28 October 1997). The clinical justification on quality grounds is not hard to arrive at either.

The question remains, however, whether the new service was what the people wanted, and in particular reference to Mäori as Treaty partners, whether they had any meaningful say in the decision; that is, whether the Crown's responsibility to consult (see Chapter 2) was discharged or not. On the face of it, this is not a question that Healthcare Hawke's Bay, its predecessors, or its advisers, appear to have ever asked themselves. The actions of the sole Mäori Board member as recorded in the minutes do not indicate a particular concern on his part. Certainly, without the benefit of interviews, there is nothing in the documentary record to indicate it was a concern for Healthcare Hawke's Bay as a whole.

A review of the processes used by Healthcare Hawke's Bay against the three Treaty principles of consultation, participation and representation throws some

light on the extent to which that lack of concern disadvantaged Mäori in Ahuriri. Discussion follows under each principle separately.

### Principle 1: Consultation

Tangata whenua of Napier believe that consultation between Treaty Partners did not occur in the decision to regionalise and relocate their health services to the Hastings Hospital site. The Mäori Treaty Partner perceived consultation to mean that their opinion would be sought, considered, taken into account and be able to influence the outcome (Tom Hemopo, Submission to Healthcare Hawke's Bay, 1 June 1994). This is quite consistent with the then Crown view of consultation. For example, the then Prime Minister, Jim Bolger, speaking to a radio audience in 1994 stated:

> I think the most important thing there Paul, is that the obligation to consult by the Crown Health Enterprises and the Regional Health Authorities, whether it's in Canterbury or Auckland or wherever, that they actually do genuinely consult. And are prepared to alter their original proposals once they have talked to the community. That's what it's all about (Bolger, Newztel Log 1ZB, 15 August 1994)

Given this, there appears to have been a lack of understanding by Healthcare Hawke's Bay of the Treaty obligations on them and the appropriate expectation that the Ahuriri community had that these be honoured.

The CHE did respond to criticisms from claimants over the issue of consultation (Heaney, 1998). When defending their consultation process Healthcare Hawke's Bay challenged the criticisms of lack of consultation with Mäori by suggesting that Mäori could have attended any of the public meetings. The suggestion appears to be that the CHE was not obliged to consult separately and specifically with Mäori. Healthcare Hawke's Bay did not see that they had a Treaty

responsibility to the Tangata Whenua separate and distinct to their public consultation obligations. The Chairman of Healthcare Hawke's Bay Board defined who, in his view, the responsibility of consultation lay with in the Napier City Council litigation.

> Mr. Wilson deposed that the Board did not regard its decision making process as subject to any duty of consultation, and drew attention to the absence of any statutory provision to that effect, contrasting it with the express obligations of an RHA (Ellis J, 1994)

However, this appears to overlook the responsibility of the CHE to comply with the State-Owned Enterprises Act:

> Section 9 of the State-Owned Enterprise Act 1986 states that "Nothing in this Act shall permit the Crown to act in a manner that is inconsistent with the principles of the Treaty of Waitangi."
>
> The principles referred to are generally agreed to be those defined by the Court of Appeal and include the requirement that the Crown act in good faith and make informed decisions. From this requirement the duty to consult has developed. So far the Court of Appeal has recognised a Treaty duty to consult Mäori "on truly major issues" (Te Puni Kökiri, 1993)

It does appear inconsistent that the Minister of Health had power to direct the RHA to consult but no such power of direction existed in the case of a CHE. In the context of the Wai 692 claim the initiative to regionalise appears to have been driven by the CHE. If so, there should have been equal accountability for the decision. The legislation stated that Regional Health Authorities were required by s34 to consult in the following terms:

> 34. Regional health authorities to consult - Every regional health authority shall, in accordance with its statement of intent, on a regular basis consult in regard to its intentions relating to the purchase of services with such of the following as the authority considers appropriate:
>
> Individuals and organisations from the communities served by it who receive or provide health services or disability services:
> Other persons including voluntary agencies, private agencies, departments of State, and territorial authorities (Health and Disability Services Act 1993)

Healthcare Hawke's Bay saw consultation as part of a public relations exercise to sell the regionalisation proposal. After the decision was made they saw that opposition could be minimised with "consultation". Healthcare Hawke's Bay and Central Regional Health Authority jointly shared the consultation.

There is no documentation that indicates that Tangata Whenua were ever consulted in 1993 when the decision to regionalise all services to Hastings was committed to. This should have occurred prior to discussions with Ministers and Treasury and as a Treaty responsibility is separate from the issue of public consultation.

### *The Consultation Process*

The Model Regional Hospital paper contained a category titled 'cultural issues' listed between the categories flexibility and staff facilities. The paper states cultural issues had been addressed in the model hospital as the design has allowed for a "Whare Whanau or rentable accommodation for those requiring private accommodation". This category also included a statement that mothers must be given choice on how they deliver their baby. It concludes with "We must respect patients right of choice" (Healthcare Hawke's Bay, Model Regional Hospital paper, 1993). It would appear that there was not comprehensive Iwi consultation in the consideration of a model hospital.

Healthcare Hawke's Bay had a very carefully planned and controlled public information and consultation programme. As indicated earlier, this was managed by Network Communications and was developed in consultation with the Healthcare Hawke's Bay Board. It was initially proposed that the process would

be described as a validation process with several phases. Critical to the process was the selection of stakeholders, representatives of interest groups, who would attend carefully controlled meetings. The stakeholders represented staff, union groups, patient groups, civic leaders, community health groups and the only reference to Mäori was a group described as Mäori groups. If the public wanted to actually meet with the decision-makers, they were expected to apply for an invitation by calling an 0800 number after April 13 1994.

Two public meetings were held on 6 May 1994 where nominations were called for stakeholders who would then attend further meetings. At the selected stakeholder meetings the case for and against a regional hospital would be presented by speakers identified as validators. This process was described by the Chairman as " an extensive process of public information to ensure that the people of Hawke's Bay with an interest in hospital services are fully informed" (Peter Wilson, Letter to Michael Laws, MP, 14 April 1994). The process was also to include the opportunity for written public submissions, and where appropriate, the hearing of oral submissions.

Further public meetings were held in the suburbs of Napier and Hastings during May 1994. It was estimated that approximately 800 people attended the public meetings throughout the process.

In a memorandum to Board members and other relevant parties, Mr. Kevin Moore a Board director stated;

> The stakeholder nominees are a critical issue. Currently our thinking is:

- It must be clearly stated what their role is. They have no power and can make no recommendations. The sole aim is to allow a group to get really close and to question the Task Force/Board/RHA/Consultants and report to their groups (Healthcare Hawke's Bay Memo from K. Moore 3 May 1994)

The participation of the validators was also carefully controlled. Network Communications suggested to the Chief Executive Officer that;

> It occurs to me that the validators need to be teed up for the second meeting of the consultation process and on stand-by for a third meeting.
>
> Talking with Derek North his major concern was not wanting to speak to a rabble-like public meeting. These stakeholder meetings will be carefully controlled and there will be adequate protection for the validators (Network Communications Memo, 14 April 1994)

This stage managed process was described in a press release by the Chairman of the Central Regional Health Authority, Hutton Peacock as, "We are satisfied that the programme is fair, transparent and well thought through and are confident that the final decision, whatever it is, will be in the best interests of the health of the people of Hawke's Bay" (Healthcare Hawke's Bay Media Release, April 1994).

For Mäori that attended the stakeholders meetings the presentations were not always easy to follow and they did not think the structure worked for Mäori.

> Quite often the speakers would talk about very technical things that were difficult for lay people to grasp what was going on. Some of the questions related to, will there be a bus for transport; will there be eye clinics. As I have experience in such things there was no discussion and people did not understand things like primary care as compared to secondary care so consultation by way of a stakeholders meeting was not appropriate. It would have been more appropriate to have consulted the formal structures that existed like the Taiwhenua Boards and the Taiwhenua itself to have a considered response to the CHE (Joe, Interview, 1994).

Healthcare Hawke's Bay consulted specifically with Iwi once,18 May 1994 at Omahu Marae Hastings, according to their documentation. It appears that

consultation to discuss the regionalisation proposal was initiated by the CHE to inform Iwi of the decision. It is unclear what degree of control Iwi had over choice of venue and the way in which consultation would be conducted. The minutes of the hui indicate that the purpose was to inform and impart information. This was consultation after the decision was made and not a dialogue that could possibly influence outcome.

Presentations were given by Healthcare Hawke's Bay and Central Regional Health Authority on issues pertaining to a regional hospital for Hawke's Bay. The summary of the joint presentation was;

- importance of spending tax dollar wisely for the community
- more dollars being spent in hospital services rather than community health projects
- need to free up dollars from hospitals for more community initiatives
- job is to ensure quality health services for the people in the community- must get this through efficiencies (Minutes of the Mäori Consultation Hui, Omahu Marae, Napier, 1994)

The irony seems to have escaped the Crown agencies; they were supposedly there to discuss a regional hospital yet their presentation comments on the need for more funds to go into primary health in the community. This appears a contradiction to the concept that they were there to sell and the statements they were making about spending less on hospitals and more on community initiatives.

Comments in the minutes of the hui indicate a poor understanding of consultation on behalf of Healthcare Hawke's Bay and the Chief Executive Officer. They denote a particular mindset. The comments from Mäori focused on lack of

consultation from the CHE, decisions being imposed and a lack of inclusion about the future development of health services in Hawke's Bay.

Mäori were critical of the assumptions inherent in the presentation. Comments from the floor challenged the language used and clarified what services would be retained and where they would be located.

> Issue has been publicised and stated by the team making the presentation that there is "one hospital". This implies the other one (Napier) is closed. Yet hearing today that in fact some specialist services are being centralised to Hastings, and Napier will continue to provide much of what it does today. CHE should get story right and present the facts- don't confuse us by talking about ONE hospital. It is one Regional hospital and three satellites - Napier, Wairoa and Waipukurau.[Agreed] (Minutes of the Mäori Consultation Hui, Omahu Marae, Napier, 1994)

At the one consultative hui (Minutes of the Mäori Consultation Hui, Omahu Marae, Napier, 1994) with Mäori, Healthcare Hawke's Bay confirmed that the Napier site would be retained.

Healthcare Hawke's Bay attempted to sell the advantages of the regional hospital to Mäori suggesting subject to funding they intended to include a Mäori Health Centre in the plans to offer a range of services for Mäori. Mäori responded with, **who had asked what Mäori wanted?** It was the consistent complaint of lack of consultation and inclusion in decision making.

- Have Mäori people agreed they want to go to a Mäori Health Unit in Hastings? Have you asked us what we want?
- Have Mäori had a say in the job of Mäori Health Manager? Have you (Alistair-Chief Executive Officer) and Pare [Niania] already decided?
- Believe we should have the same access for resources as the CHE. Maybe services need to be revamped so we can play a part. Needs to be far more consultation with us.
- Mäori have not been consulted about the Mäori Health Centre. MWWL make a submission that we want two hospitals.

> Problems with transport. Napier could have a helipad for instance, if there were less carparks for staff (Minutes of the Mäori Consultation Hui, Omahu Marae, Napier, 1994).

The response of the CHE demonstrated their difficulty with the concept of partnership. The Chief Executive Officer is documented as replying;

- the job of Mäori Health Manager will be advertised. Not sure what input you want in the process. Person works for me. Cannot work for two bosses- accountability issues. However can see you want a say in it- will have to find a way to achieve that.
- Establishment of the centre will depend on Central Regional Health Authority funding-have not put proposal in yet (Minutes of the Mäori Consultation Hui, Omahu Marae, Napier, 1994).

An unidentified speaker from the floor challenged the CHE on its proposal to establish a Mäori health facility and whether it was the most appropriate provider, "CHE has stolen a march on Mäoridom. You are another service provider like many Mäori groups. You are a competitor. If you have a Mäori Health Centre you have beaten us to the mark" (Minutes of the Mäori Consultation Hui, Omahu Marae, Napier, 1994).

There was criticism from the hui of the Mäori policy for the CHE. The comments reinforce the lack of involvement of Iwi in all aspects of decision making from the regional proposal, resource allocation, staffing, and policy development. "Saw a version of your Mäori policy for the CHE. Looked like a Government proposal with Mäori people in it. Needs a sixth unit- Rongoa. Kaupapa needs to be Mäori- at present your kaupapa is Government. We can determine our own structures" (Minutes of the Mäori Consultation Hui, Omahu Marae, Napier, 1994).

The response from Healthcare Hawke's Bay to such comments does not indicate an understanding of their Treaty obligations and the implications for health. The Chief Executive Officer gave an opinion on the place of rongoa, " As far as traditional medicine concerned, think it is difficult to have two styles of health at the same hospital. Think it is wrong to have western medicine in a hospital environment mixed with traditional Mäori medicine in a hospital environment" (Minutes of the Mäori Consultation Hui, Omahu Marae, Napier, 1994).

A speaker from the floor identified the source of conflict with the CHE, " Believe communications from CHE could be a lot better. We as Mäori hear very little indeed. Needs to be updated and brought back to the people. The Advisory group needs to be chosen by the people. We need to be consulted" (Minutes of the Mäori Consultation Hui, Omahu Marae, Napier, 1994).

The Mäori community viewed the consultation process as less than adequate. Te Maari Joe attended a stakeholder meeting and the Omahu Marae consultation, and was critical of the CHEs communication style and monocultural approach. As she commented one call to Mäoridom is not enough as it depends on who calls the Hui.

> My knowledge of the consultation process and the changes that were to happen to the hospital are by reading the papers. The Te Taiwhenua Board which I assist with was not part of the negotiation process with the CHE. It appears to me that the negotiations followed after the decision was made.... I attended the Hui at Omahu and it is from that Hui which was after the decision was made that people were "consulted".
>
> It seems to me that it was not consultation, that the CHE was reporting on its vision.

> The Board (Hauora) was not approached at any time but the CHE seeking the Board's view. They did not come here and there is no records or documents. Nor did we participate directly in the negotiations.
>
> I found out about the Hui at Omahu from (identified kuia) who telephoned me informing me that a Hui was to be held. I was informed by her that she had met a CHE Board member in the street and who had been told that the decision was made fait accompli before the Hui was held.
>
> I attended the Hui at Omahu which was merely reporting, telling us what was going to happen and we were told by Mr. Bowes not to worry. It gave us the feeling that things had already been settled, that decisions had already been made and we were being spoken to as we have for the last 150 years (Joe, 1998)

Te Maari Joe also made a submission to Healthcare Hawke's Bay on behalf of the Taiwhenua and Hauora Board of the Whanganui-a-Orotu, and the Mäori Women's Welfare League on 1 June 1994. The submission made several suggestions including;

- The Taiwhenua and Hauora Board stress the value of people as against bricks and mortar.
- The Taiwhenua and Hauora Board agree that there be two hospitals.
- The Taiwhenua and Hauora Board recommends that Mäori people and Mäori organisations must be consulted on any issues affecting Mäori.

Mrs. Joe was also invited to make a submission before the Healthcare Hawke's Bay Board. She states she was told what she could speak about and was confined to commenting on the Mäori Health Unit.

> We were told how long we could speak and I spoke after Tom Hemopo and talked on the Mäori unit stressing the fact that there was no consultation with Mäori through our areas.... It is my view that the Hawke's Bay area needed to be required(consultation) because the proposal is for a Hawke's Bay regional hospital and that people from these areas needed to be consulted. That would have required a Hui. ...
>
> Although I was to go and talk about my submission with other Mäori it was really on behalf of the Mäori health unit. I do not feel that I was able to speak for Mäoridom as a whole as I am not authorised to do so (Joe, Interview, 1988).

When Bridgeport consultants John Hill and Robyn Goldsmith reported to the Healthcare Hawke's Bay Board at their meeting of 10 June 1994, the Board minuted:

> Four or five submissions had been received from Mäori organisations, as well as the report of the hui held at Omahu. The general feeling from those submissions was for the status quo to remain and some references had been made to a perceived inadequacy in the consultation process.

Nothing further is recorded other than that the consultants were thanked for their presentation.

In the 1997 round of public consultation over services to be retained and located in Napier there were three public meetings. The documentation from Healthcare Hawke's Bay indicates that there was not a specific consultation meeting with Iwi. It was suggested in the response from Healthcare Hawke's Bay to the Statement of Claim that there had not been a lack of consultation as local Iwi and other Mäori could have attended general public meetings.

Network Communications continued to manage Healthcare Hawke's Bay public relations work and refined their understanding of public consultation. In a memorandum from them to the Chief Executive Officer an opinion has been given on the management of the Napier services "consultation" in 1997.

> It is important from the outset that we establish the exact status of any discussions that might take place, because our experience suggests groups such as the Napier Hospital Retention Group will attempt to manipulate anything we do to suit their broader political objectives.
>
> There is a danger that they will attempt to use activities we may initiate to gain community comment, not to debate the configuration (within the framework provided by the RHA purchasing policies), but to campaign for the retention of Napier Hospital in its current form. It is also possible, for example, that they will try and "filibuster" the process by making dozens (possibly hundreds) of submissions and wanting them all heard publicly.

There is also the danger of inadvertently creating an expectation that we are undertaking a full public consultation and all that implies in terms of process.

Any process of discussion or comment that we initiate has to be carefully defined and specified.

I would make the following suggestions:

- that the terms of the public discussions are clearly spelt out (eg. that Healthcare Hawke's Bay has no legal requirement to consult, but wants comment on its proposals from interested groups)
- that very specific questions are posed on which comment is sought
- that submissions are received, but are not actively pursued, and that they are called "commentary"
- that no hearings are held, although Healthcare Hawke's Bay retains the right to follow-up with any commentators on specific issues

I believe we should avoid public meetings. They are simply an invitation for participants to push political agendas and contribute little to constructive discussion (Henley, 1997)

Specific groups were identified to be included in the "consultation" process. The groups were identified as, GP's, Napier City Council, Napier Services Retention Group and the Hawke's Bay Health Council. There were no references to any Iwi or specific Mäori group who should be consulted or met with.

The Chief Executive Officer of Healthcare Hawke's Bay when questioned about the document was emphatic that it was not a memorandum but the jottings between two colleagues, not intended for public perusal, and that it had been stolen from his office. The presentation of the document suggests otherwise. It is titled memorandum on Network Communications letterhead, dated, to be sent to identified staff other than the CEO, and the subject was on the Napier services

consultation. Mr Flowers' discomfort with the circulation of the document was clear from his reaction, though the reasons for that discomfort remain open to speculation.

While Mr. Flowers said he did not follow the advice given, it was consistent with the management of previous public consultations. There has been no evidence supplied or uncovered in this research study of an alternative approach or recommendations.

The lack of consultation and the manner in which it was conducted was an issue for the wider community. In 1997 Neil Kirton, the then Associate Minister of Health, commissioned a personal review of Napier hospital services and the consultative process with the people of Napier. The review was to examine the process Healthcare Hawke's Bay used when consulting with the Napier community. "There has been enormous public criticism and an explicit lack of confidence from many Napier citizens in the processes that led to the regional hospital decision" (Kirton, 1997).

A retired medical practitioner from Napier Dr Brian Woodhouse was to conduct the review and submissions were invited from the public. In his report Dr Woodhouse concluded that "I think the public consultation process was completely adequate" (Kirton, 1997).

Neil Kirton stated when interviewed that one of the shortcomings of the report is that it did not consider the Mäori perspective or address their concerns (Kirton,

1997). While the 1997 review may have found consultation adequate from the reviewer's point of view it was not for the Tangata Whenua of Ahuriri. They considered that the CHE had Treaty obligations to honour as a Treaty partner, that is the fundamental difference to its obligations to the wider community.

At the second Stakeholder meeting, 23 May 1994, a question was asked from the floor, "Won't the residual services at Napier be moved away eventually and the hospital closed?." The response from the presenters was, "That is not the plan." (Minutes of the Mäori Consultation Hui, Omahu Marae, Napier, 1994). It has to be asked what exactly was being consulted about in the consultation process. Was this consultation before the decision making process or was the decision already made, and the "consultation" a sham? There was not public consultation to debate or consider the closure of Napier Hospital. The 1997 public consultation exercise was focused on what services would be retained in Napier and where they would be located.

### Principle 2: Participation

Participation in decision making is the second treaty principle recommended by the Royal Commission on Social Policy and refers to Mäori involvement in a particular activity or sector. Mäori participation has historically been marginalised in the health sector with the increasing reliance on health professionals.

The Waitangi Tribunal set out its expectations of participation in the following form:

> ... in a society based on a partnership of two peoples, the achievement of social goals requires the active support and participation of both. Inevitably, then, the tighter the control that one party exerts over social

> policy, the less the other is able to contribute, and the less likely the goals are to be reached. It appears to us that Crown agencies cannot exclude the values and aspirations of communities unless they are totally incompatible with Crown goals (Waitangi Tribunal, Te Whanau o Waipereira Report, 1998, p232)

When the Taskforce report was completed in early 1994, the process of public submission and comment included:

- An 0800 number whereby people could make oral comment
- An opportunity to make written submissions
- The possibility of being invited by the Healthcare Hawke's Bay board to make an oral submission in support of the written submission.

However, without access to the Taskforce report, the process of making submissions was difficult. Healthcare Hawke's Bay charged 20 dollars per copy of the report. However, Network Communications advice to Health care Hawke's Bay was:

> Some copies will need to be provided free and others for perusal to avoid the accusation that the decision process is inaccessible to community members (Network Communications, 1994).

In the event, 4 copies were reserved for local Iwi and one for the Mäori Community Health Group. It is evident, that for Mäori to make submissions in the traditional way, by korero with the decision-makers, the hurdles were substantial. In the end, such submissions were only by invitation, with the exception of the Omahu hui

In the review mentioned in the previous section conducted by Dr Woodhouse in 1997 he stated (Kirton, 1997) that there was a widely held concern within the community over the lack of community participation in the activities of Healthcare Hawke's Bay. The new structure of Crown Health Enterprises

removed democratically elected Board members who were replaced with appointed Directors who were not necessarily local or known to the community. This contributed to a sense of reduced accountability of the Board and subsequent lack of transparency in their activities.

> A recurring theme concerned the structure of the CHE Board. Nearly everyone agreed that the company structure makes for easy and effective decision-making but there is also a substantial feeling of loss of participation in the system. When elected representatives ran the hospitals they were "ours" in a sense that no longer applies. The consensus was that a mixed governing body, with a small majority of appointed members and some elected representatives, would be the best structure (Kirton, 1997)

It has been difficult for this researcher to establish fully how Mäori participated in the day to day running of Healthcare Hawke's Bay without interviewing the relevant staff. Permission to interview them was refused by the CHE, though some staff members gave evidence at the Wai 692 hearing before the Waitangi Tribunal. Examination of Healthcare Hawke's Bay reports on the regionalisation proposal (1994) and Napier Services Working Party (1997) indicates that Mäori membership of such groups was low to non-existent.

The membership of the Napier Services Working Party consisted of clinical and support staff of Healthcare Hawke's Bay, consultants such as Network Communications and a union representative. The non-Healthcare Hawke's Bay members were community based and consisted of a General Practitioner, a Napier City Councillor, Hawke's Bay Health Council representatives and the General Manager for a medical practice. Members were appointed by the CHE and those from the community were invited to participate.

There appeared to be no specific Iwi representative or the inclusion of any representative from a Mäori community group. In the deliberations and considerations of what services should be retained and located in Napier there was not a Mäori perspective in the formal decision making group.

Healthcare Hawke's Bay has commented that Mäori were considered and consulted adequately about the Napier services report in 1997. They have outlined how this was achieved.

> Prior to the presentation of that report and the public consultation Healthcare Hawke's Bay executive Bill Hodges (Manager, Mäori Health) whose function was to liaise with the Mäori Health Committee ensured that matters of concern or material to Hawke's Bay Mäori including those at Napier were considered (Heaney, 1998).

This statement appears to be saying that Mäori matters were effectively marginalised and delegated to the Mäori Advisory Committee. There does not appear to have been a consciousness that any decisions or factors affecting Mäori should be incorporated into all aspects of decision-making. Not all Mäori considerations or concerns should have gone solely to the Mäori Committee. Participation in decision making, partnership in the Treaty of Waitangi sense, would have required a greater level of participation by Mäori at all levels of decision making within Healthcare Hawke's Bay. A single hui and a single advisory committee were arguably not adequate participation.

### Principle 3: Representation

In 1986 the Board of Health issued a statement that acknowledged the need for formally recognised Mäori representation at board level.

> Affirmed the need for special representation of Mäori people on all hospital and area health boards. In addition to encouragement for Mäori people to stand for election as individuals, the Board of Health believes

> that provision should be made for the appointment of Mäori representatives selected and determined in accordance with Mäori culture and tradition (Department of Health, 1987,88)

There has been concern expressed by Mäori about the lack of Mäori representation at the senior levels of decision-making in the health sector throughout the period under study (Cunningham & Durie, 1999). The issue of representation was recognised by the Department of Health. In its 1986 memorandum 'Treaty of Waitangi and Mäori Health', it recognised the need for greater participation and representation of Mäori in the development and delivery of health services: "That Mäori health issues be addressed by the involvement of a greater number of Mäori people in the delivery of health services and the setting of priorities... challenges health decision makers to involve Mäori people in the development of plans and priorities" (Department of Health, 1987, p88).

Effectively a Mäori perspective at the most senior levels of management would only occur when there was adequate Mäori representation at board level. The Department of Health recognised this and reminded Area Health Boards that adequate levels of representation might only be achieved if Mäori selected by their communities were appointed by the government to the Board (1989 onwards). There was legislation that supported and protected this option. Mäori representation could not be guaranteed through elections. The legislation provided a mechanism for Boards to ensure they had adequate Mäori representation, through a system of government appointments. "This approach is supported by the Board of Health as the most effective way of ensuring adequate Mäori representation" (Department of Health, 1987, p88). The Board of Health was the national collective body of Hospital Boards and latterly of Area Health Boards.

The active support for Mäori representation was less visible in the 1990s after the 1993 reforms. The structure of the new entities known as Crown Health Enterprises saw less commitment to such initiatives. The Health and Disability Services Act 1993 contained no requirements for representation by Mäori on Boards of the new health bodies. The Boards of CHEs were wholly government appointed. Where Boards did have Mäori directors, they were not necessarily either local or mandated by Iwi to represent their views. The number of Mäori directors in 1999 of HHS companies was fifteen out of a total number of 133. (Oral Interview, McLean, 1999)

Directors were appointed by the shareholding Ministers, the Minister of Health and the Minister of Finance. The Crown Company Monitoring Advisory Unit recommended possible candidates to the shareholding Ministers:

> Recommendations take account of the need to ensure each board has an appropriate balance of skills and knowledge and a composition (in particular in relation to gender and ethnicity). CCMAU maintains an extensive database of actual and potential directors and actively seeks CVs from a range of people - including by way of public advertising for those interested in acting as directors of Crown companies.
>
> Recent changes to policy have encouraged local authorities to nominate candidates for consideration for appointment by Shareholding Ministers to HHS boards. However, those appointed as directors (regardless of the way in which they may have been nominated) are not appointed as representatives of any particular body, community, profession or other group. They are appointed to act as directors of the company - the primary legal duty of directors is to act in the best interests of the company, not the interests of any group they may belong to or wish to 'represent'.
>
> While the decision to appoint directors is for the Shareholding Ministers alone, Government policy is that as part of the appointment process those decisions must be ratified by the Appointments and Honours Cabinet Sub-Committee.
> (CCMAU Record of Meeting of 12 March 1999)

CCMAU took a commercial approach to its role and the role of the Directors it appointed. CCMAU identified its role in respect of the health sector as advising shareholding Ministers on the balance between public policy objectives and efficiency objectives (CCMAU, 1999). It had previously been criticised for an undue focus on organisational and financial performance of CHEs (Stent, 1998). CCMAU's response to the Health and Disability Commissioner was to state that "many of the comments and observations made in relation to CCMAU arise from misunderstandings of CCMAU's role" (Stent, 1998). It is hard to see how public policy objectives in relation to Mäori health could be brought into the balance if those public policy objectives could not be brought to bear on the appointment of the directors who run the Crown companies.

Mäori make up seventeen percent of the Napier City population. They have the worst health status in the central funded region of the HFA as outlined in the second half of this report. How then were Iwi represented in the largest health provider of the Hawke's Bay separate to their role of consumers?

The Board of Healthcare Hawke's Bay from 1993 – 1999 had nine directors who met monthly. At these meetings the Company direction, policy and objectives were set and their progress reviewed. The Shareholding Ministers had laid down the responsibilities of the Board:

- To manage the Company so that they achieve the targets established for the business in the annual business plan and Statement of Intent.
- To act in a manner consistent with their directors' obligations under the Companies Act 1993 and the shareholders interest (Healthcare Hawke's Bay, Financial and Operating Report, 1999)

Healthcare Hawke's Bay had one Mäori Director Mr. Walter Wilson who was on the Board for six years. Mr. Wilson was from Ngati Kahungunu ki te Wairoa. He initially consented to be interviewed for this study but then withdrew. His impressions and perspective would have been valuable as he was one of the longest-serving Directors. He had participated in decisions that the Board have taken and has also been the target of significant criticism from within the community who feel he had not represented their interests (Meeting at Mäori Women's Resource Centre, 27 January 1999)

In the management structure of Healthcare Hawke's Bay Mäori representation had been limited. In 1996 Healthcare Hawke's Bay appointed a Manager of Mäori Health Wiremu Hodges. His role in the management structure was elevated to the second tier after a recommendation from the Mäori Health Committee. Mr. Hodges held this role for two years and resigned in 1998.

His role, as he described it (Wiremu Hodges, interview with author, 20 January 1999), was to establish a sound Mäori health policy. He believed this would be the foundation for future Mäori health development in the Hawke's Bay. Mr. Hodges felt he was effective in gaining some recognition for Mäori at the executive level within Healthcare Hawke's Bay as until 1996 Mäori were not alluded to in the business plan.

Interviews with the staff of the Healthcare Hawke's Bay Mäori Health Unit were requested, agreed to and then later refused by Healthcare Hawke's Bay. Those staff came under the management of the Mäori Health Manager and implemented

Healthcare Hawke's Bay policy in their service delivery. They were perfectly placed to provide information on the day to day effect of their work within Healthcare Hawke's Bay, and the effectiveness of their representation of Mäori health interests and issues. The documentary evidence provides little information as to the impact of the Mäori Health Unit. The Mäori Health Unit staff could have provided a first hand account of the integration of Mäori issues into Healthcare Hawke's Bay's decision making processes, and would have been in a position to clarify if that did in fact occur.

At the Omahu Hui in 1994 attendees requested a Mäori Committee or Advisory group be established and be involved in the decision-making process of Healthcare Hawke's Bay and report back to community. The Advisory Committee was created in 1994.[11] In 1996, with the appointment of the Mäori Health Manager, new terms of reference were developed for the committee. The source of these terms of reference is unclear. Once again, an interview with relevant staff or Board members who sit on the committee could have clarified this issue.

The Committee consisted of eight members who were elected by hui of whanau, hapu and Iwi in each of the four geographical areas of Hawke's Bay. At each monthly meeting Executive staff, Board members, Manager of Mäori health and relevant service managers of Healthcare Hawke's Bay would also attend. The CHE's statement to the hearing requesting urgency on the Wai 692 claim

[11] There is little documentary evidence of the Committee. It has been hard to establish any details of its history in the period 1994-96 without access to relevant staff. It is not visible in the CHE business plan, or in the Board minutes as supplied by Crown Law Office where large sections had been excised.

mentioned the makeup of the Mäori Health committee, but made no mention of the details of its monthly deliberations between 1994 and 1996.

The main purpose of the Committee was defined as receiving information from a variety of sources on Mäori health, disseminating it to the relevant sources (Terms of Reference, Mäori Health Committee, undated)and maintaining a monitoring role of services delivered to Iwi.

There was no obligation on Healthcare Hawke's Bay to incorporate or implement recommendations from the Committee. As the terms of reference state, the Mäori Health Advisory Committee was one of several such groups advising Healthcare Hawke's Bay on matters relating to health.

In July 1996 a Mäori Working Party was convened to provide cultural advice on the design and layout of the planned Regional Hospital. The membership appears to have been drawn initially from Healthcare Hawke's Bay staff and subsequently selected individuals from the community. The minutes indicate that their purpose was to awhina and support:

- Advice on internal design and layout
- Staff training on why the design is culturally appropriate
- Staff need for Kaumatua support
- Work with other staff to get their ideas on sensitivity and cultural appropriateness (Te Komiti Mäori Awhina, Minutes of Meetings - 23 July 1996, 7 August 1996)

The minutes of these meetings stop at September 1997. It is unclear whether the group continued to meet or that their advice was incorporated into the design and overall cultural appropriateness of the facility.[12]

Some of the issues they raised and the response from the organisation suggest a lack of cultural awareness and appropriateness. For example, at the November 1996 meeting the Committee discussed the issue of the storage of body tissue. The response from staff at the mortuary was that there was no facility for that and that they did not see it as their responsibility. This issue was discussed at a further two meetings. At the February 1997 meeting it was suggested that the responsibility lie with the individual and be further debated. The last set of minutes supplied is for the August 1997 meeting and the body tissue and parts issue still had not been resolved.

This researcher argues that Mäori working parties or advisory groups provide the organisation with the Mäori perspective or opinion on specific issues defined as pertaining to Mäori. They do not adequately address what efforts the CHE makes to incorporate a Mäori perspective in all aspects of decision-making. There is also no obligation on the CHE to implement any decision or recommendation from advisory groups or committees. Without the opportunity to discuss these issues through interviews of Mäori Health Unit staff, it is quite impossible to arrive at any conclusions as to the adequacy of Mäori participation in decision-making and representation on decision-making bodies.

---

[12] All minutes of the Working Party were requested through the Crown Law Office. No further minutes were supplied.

## Unilateral Changes and a Failure to Partner with Mäori

The core of the issue in the contemporary context was the inclusion of Mäori in the decision making process. Who determined what was best for Mäori in Napier? The Wai 692 report stated that it could not be demonstrated that Mäori were consulted in a true and meaningful way, and therefore able to participate with adequate representation at all levels of decision making.

> Healthcare Hawke's Bay and its predecessor organisations have not considered the healthcare and health status of Napier Mäori as a significant issue in their service delivery planning. They have not offered Mäori an opportunity through consultation, participation or representation to effectively join in the decision-making processes affecting their health and healthcare (Ferguson, 1999b, p41).

The Wai 692 claim highlighted the fragmented accountabilities within the health sector. It raised issues of monitoring and implementation and the responsibility for monitoring the Crown entities.

> Government monitoring agencies appear to believe that in the 1990s, Crown Companies will not breach the Treaty, therefore monitoring is not required. It is evident that if it is not explicit in the monitoring role and enforced, self-monitoring is not adequate. This report demonstrates that the expectation that HHSs will comply is not sufficient and that rigorous monitoring is required (Ferguson, 1999b, p42).

The Wai 692 claim explored the relationships within the health sector and how they worked towards improving health outcomes for Mäori. The inconsistencies of the sector were apparent.

> Measurement of health status by the provider and the purchaser has been piecemeal, and hampered by poor information collection and analysis. CCMAU has been slow to change the framework of the quality indicators reported to it, and shows no likelihood of considering Mäori health outcome a significant quality indicator for HHS's. The requirement to "involve Mäori in the development of quality measures for tertiary services, in relation to access, transport, whanau support, and accommodation" appears to have passed the Mäori community of Napier by (Ferguson, 1999b, p42).

The Wai 692 claim also raised the issue of what is adequate consultation with Tangata Whenua. The claimants challenged the adequacy of one consultative hui that took place in Hastings in 1994. Healthcare Hawke's Bay attempted to argue that they had no legislative requirement to consult and that the responsibility for consultation rested with the RHA/HFA.

The Auditor General's report (1998) would suggest that there was a requirement on any Public Sector Organisation to consider the Government's strategic goals, involve Mäori in the planning process and identify potential Treaty Issues with any strategic planning.

The report to the Waitangi Tribunal concluded that in the context of the claim Mäori were not consulted as a Treaty partner. There was no documentary evidence to show Mäori had any meaningful and satisfactory participation in the major decisions that would have a fundamental impact on their access to local health services.

The fundamental issue in the claim was identified as, "if Mäori are excluded from the pivotal decisions that will have significant impact on their health status, who will protect the Treaty rights of tangata whenua?" The claim proposed that "The Crown and its relevant agencies, Healthcare Hawke's Bay, Central Regional Health Authority and CCMAU have not protected and upheld the Treaty rights of the peoples of Ahuriri".

The Tribunal decision in respect of Wai 692 - The Napier Hospital and Health Services Report (Waitangi Tribunal, 2001) was released in October 2001.The Tribunal found over 100 breaches by the Crown in the decisions it made and the processes it used regarding Napier Hospital and health services. The claim and the Tribunal's consideration of it illustrate the degree to which the Crown was found not to have lived up to its Treaty obligations in respect of Mäori health. The Tribunal found that the Crown has failed at all levels, in its legislation setting, in its instructions to its agencies, in its consultation processes, in its affording Mäori the opportunity to participate and be represented in decisions that effect them. Furthermore, it found that the Crown had at times breached the duty of good faith conduct.

The Wai 692 claim serves as a robust and concrete illustration of the degree to which the Crown has attempted to remedy Mäori health status in a unilateral way. Its failure to use a partnership consistent with the Treaty of Waitangi, to act in line with the Treaty principles of consultation, participation and representation, has not enhanced the health status of Ahuriri Mäori. Neither has it met their aspirations, voiced over many years, for participation in health sector decision making (Waitangi Tribunal, 2001, p361).

Changes in governing party or parties, and consequent shifts in ideology over the period of this study were considered not to have had a positive effect, either in perceived improvement in health service delivery, or in engaging Mäori as partners in the health sector, or in determining their collective health status (Waitangi Tribunal, 2001, pp363-373). To what extent then, can the lessons of

Wai 692 be seen as applicable across the whole of the health sector? The next chapter highlights the effect of such unilateral change, and the Crown's attempts through policy development and monitoring to address Mäori health issues.

# CHAPTER 7 - CROWN ACCOUNTABILITY TO MÄORI - MONITORING OF THE HEALTH SECTOR AND ITS IMPACT ON MÄORI

## Government Policy - Mäori Health is a Priority

This chapter investigates the strategies and policy statements of successive governments to address Mäori health needs within the period of this study. It will review policy documents and interview material from health sector participants to understand what has been implemented and how it has been monitored. The processes the Crown has put in place to monitor the effectiveness of their own strategies will also be examined. These will be used to investigate the Crown's delivery of health services to Mäori consistent with its Treaty obligations as outlined in Chapter 2.

Government policy in respect of the Treaty of Waitangi and of Mäori has occupied both a generic and overarching space, and more specific sectoral contexts, at least since the time that the Third Labour government restored the Treaty to a statutory role with the Treaty of Waitangi Act 1975. That is not to imply a level of consistency between successive governments beyond that of an acknowledgment of its status as a 'founding document'(Whaia te ora mo te Iwi, 1992). There is an abundance of references to the Treaty of Waitangi in recent government Mäori health policy. In generic strategic policy documents over the time of study the Treaty has often been acknowledged in terms of the "special

relationship between Mäori and the Crown," or acknowledging the unique needs of Mäori as tangata whenua (Moving Forward, Ministry of Health, 1997).

More specific Mäori health policy documents do make some effort to turn Treaty acknowledgment into Treaty based action. There has been no shortage of policy, indeed, it exists in abundance. However, there appears no sense of a unified approach to the Treaty and its role in health. The following display of key policy milestones (Table 6) during the health reforms of the last two decades highlights the inconsistencies and the variety of meaning placed on the Treaty in recent times. It highlights the inability of the Crown to sustain a clear view of the Treaty through the cycles of political change, and the variety of approaches used to try and operationalise the Treaty in respect of Mäori health status improvement.

# Table 6: Selected Milestones in the Development of Health Policy to Improve Mäori Health

| Sector Change | Policy Milestone | Strategies and recommendations | Outcome |
|---|---|---|---|
| **1984 - Labour Government** | Mäori Policy | Minister of Mäori Affairs, Koro Wetere, strongly supported the concept of devolution of activities from the State to Iwi. This reflected perhaps an amalgam between the Labour government's initial intentions to 'honour the Treaty' (Kelsey, 1990, p46) and the shift from universal welfarism to greater individual responsibility. | Disestablishment of the Department of Mäori Affairs, and incorporation of performance expectations into mainstream Crown agencies. |
| **1984 -1994** | Decade for Mäori Development (Hui Taumata) (Public Health Commission, 1994, p59) | • 'a greater focus on Mäori self-determination utilising Tribal structures'<br>• ' integrated cultural, social, and economic development, positive funding (rather than negative spending), greater Mäori autonomy, and Mäori self-determination' (Durie, 1994, p.54)<br>Mäori development begins to be seen as a remedy for Mäori social ills, and opens the way for shifting the Mäori burden off the State. | The beginning of Iwi social and development programmes. |
| **1988** | Te Urupare Rangapu (The Partnership Response) Department of Mäori Affairs, 1988 | • Improve responsiveness of government agencies<br>• eliminate the gaps which exist between the educational, personal, social, economic and cultural well being of Mäori people and that of the general population.<br>• promote decision making in the machinery of government, in areas of importance to Mäori communities<br>• provide opportunities for Mäori people to actively participate, on jointly agreed terms, in such policy formulation and service delivery.<br>An Article 3 based approach, where Mäori would finally enjoy the same rights and privileges as their fellow citizens. | Legislation that gave effect to the Te Urupare Rangapu policy was repealed following a change of government in 1990 (Labour to National) and subsequent redefinition of government Mäori Affairs policy in 1991. "The only attempt by any government to work with the resilient Mäori cultural structures of whanau, hapu, iwi and marae." (Parata, 1994, p46) |

| Sector Change | Policy Milestone | Strategies and recommendations | Outcome |
|---|---|---|---|
| **1990** | Wahanga Hauora Māori Treaty Framework Māori Health Team within the Department of Health | Area Health Boards could evaluate their performance against Treaty of Waitangi obligations by answering eight questions:<br><br>• What Crown Treaty principles are addressed?<br>• How are government objectives for Māori taken into account?<br>• What impact will there be on and for Māori people?<br>• What resources are allocated to Māori strategies and priorities?<br>• What gaps or inaccuracies in data have been identified?<br>• How are Māori involved in the development, implementation, and review of the policy?<br>• Have Māori priorities and issues been identified and addressed?<br>• Does the proposal reflect Māori values and concepts?<br>A short-lived opportunity for Treaty partnership to effect the delivery of health services, attempting to meet the intent of Te Urupare Rangapu. | Area Health Boards were abolished in the Health sector reforms of 1991. |
| **1991 National Government - the Funder/ Provider split** | Ka Awatea A report of the Ministerial Planning Group (1991, p9) | Given that Māori aspirations are seen by Government as "positive" and therefore worthy of support and encouragement, and the state-dependency of Māori as "negative" and therefore to be discouraged, it would follow that Government policy should be formulated accordingly.)<br><br>The recommendations for health were:<br>• That any future policy emphasis in Vote: Māori Affairs include a strengthened health policy function.<br>• That a Health Promotion Programme be established within Vote: Māori Affairs.<br>• That a Health Promotion Unit be established within the operations function of the proposed new specialist Māori agency.<br>• That the health promotion function have a regional presence in the proposed Regional Development Agencies.<br>• That community health initiatives continue to be enhanced and promoted as legitimate mechanisms for reaching and catering for the needs of Māori people.<br>Māori health policy would be driven from within government, rather than by partnership. Māori development is promoted to reduce Māori dependency on the State. | The report and recommended policies were never implemented as Winston Peters was demoted from Cabinet and lost the Māori Affairs portfolio. |

| Sector Change | Policy Milestone | Strategies and recommendations | Outcome |
|---|---|---|---|
| **1991** | Your Health and The Public Health Minister of Health Green and White Paper (Upton, 1991, p70) | 'Reform of our health system is worth doing only if the outcome is a better system with benefits for all New Zealanders. We must be quite clear about the goals we set ourselves and realistic about what can in fact be achieved.<br><br>The primary objective of this reform process must be to secure, for everyone, access to an acceptable level of health care. Low income should not create a barrier to quality care.'<br><br>The document, which became the blueprint for the 1993 reforms pays scant attention to Mäori or Mäori health (one and a half pages of a one hundred and fifty-three page document). It makes no reference to the Treaty of Waitangi. It fails to signal to the health sector the government's position or perspective on Mäori health when significant structural change is being proposed.<br><br>The report makes reference to Ka Awatea and the need for Mäori to participate "fully and in and contribute to the development of New Zealand". The suggested remedy is " Positive incentives must be given to Mäori as individuals and as members of whanau, hapu, iwi and other community groups to take responsibility for their own health". | It is not clear from reading the report what degree of consultation with and participation of Mäori was intended or occurred. Your Health and the Public Health contradicted previous policy that recommended participation of Mäori in the development, implementation and review of policy. |
| **1992** | 1992 He Kaupapa ... He Hanga Tikanga - A Foundation... Shaping a Way Mäori caucus of the Ministry of Women's Affairs | The plan provides a useful framework for assessing a Government department's capacity to respond to Mäori. The plan was divided into three main sections, Treaty of Waitangi, Relationship with Mäori, and Management of the Ministry, each of which had their own set of objectives.<br><br>The objectives relating to the Treaty of Waitangi included measurement of Treaty obligations and human resource policies. To assess the Ministry's effectiveness in their relationship with Mäori, account needed to be taken of:<br><br>• the incorporation of kaupapa Mäori in policy advice<br>• Ministerial services<br>• information services<br>• human resources<br><br>The management objectives were to ensure that all aspects of organisational management were responsive to the needs and aspirations of Mäori. | It has been difficult to ascertain how widely accepted and implemented the responsiveness plan was across the state sector. It appears to currently not be used within the state sector. |

| Sector Change | Policy Milestone | Strategies and recommendations | Outcome |
|---|---|---|---|
| **1993** | Treaty Framework for North Health Regional Authority G Doherty and M Durie | This Treaty framework model was described as dual focused as it combined Treaty provisions and Treaty principles. The framework provided a comprehensive template to assess the development of strategies to achieve gains in Mäori health. The three key Treaty provisions were each derived from an article of the Treaty. Kawanatanga is from Article one. Tino Rangatiratanga from Article two. The third provision was oritetanga from article three and guarantees equality and equity between Mäori and other New Zealand citizens. The three Treaty principles were defined as:<br><br>• partnership,<br>• participation<br>• active protection.<br>The framework endeavoured to bring Mäori ways of doing and being within the operation of a mainstream organisation. The establishment of joint purchasing arrangements with Iwi reflect some success in this approach. | It is not evident whether the wider health sector considered or utilised this framework. North Health was absorbed into the Health Funding Authority following the 1996 election. |
| **1993** | Public Health Commission | The Public Health Commission (PHC) was established in June 1993 under the Health and Disability Services Act 1993 to improve and protect the public health and to meet the Crown's objectives for public health. The Public Health Commission's areas of responsibility included:<br>...<br>• the public health needs of Mäori and of special groups. | Two years later the Public Health Commission was disestablished and its functions were integrated into the Ministry of Health and Regional Health Authorities. |

| Sector Change | Policy Milestone | Strategies and recommendations | Outcome |
|---|---|---|---|
| **1994** | He Matariki: A Strategic Plan for Māori Public Health 1994-1995 - The Public Health Commission | He Matariki 's six Māori public health goals were developed in consultation and were compatible with wider aspirations of those working in Māori health. They were<br>• To promote a social and physical environment which improves and protects whanau public health.<br>• To improve and protect the health of tamariki.<br>• To improve and protect the health of rangatahi.<br>• To improve and protect the health of pakeke/matua.<br>• To improve and protect the health of kaumatua.<br>• To improve Māori health status so in the future Māori will have the opportunity to enjoy at least the same level of health as non-Māori.<br><br>Each goal had several objectives that assisted the health sector to implement appropriate strategies to achieve the best outcome.<br>The Public Health Commission acknowledged the place of the Treaty and its responsibility to address Māori health inequities, but not the place of Māori in determining how and by whom that might happen | He Matariki has been the most specific policy document in terms of setting out what the health sector needed to do to make a difference to Māori health status. It assisted the sector by describing the course of action required to deliver on the goal. By comparison, many other health policies have been generic and lacking specific detail to aid in translating the policy into action. |
| **1994** | The CHI Model - A Culturally Appropriate Auditing Model, M Durie 1994 for the Public Health Commission | Based on seven themes and for each theme a number of indicators were proposed and others could be included. The themes were grouped into three major goal categories:<br><br>• Goal: Māori Development<br>Themes: The Treaty of Waitangi, Empowerment<br>• Goal: Health Gains For Māori<br>Themes: National Standards and Government Obligations, Data and Information , Active Involvement<br>• Goal: Māori Cultural Values and Beliefs<br>Themes: Cultural Safety, Intellectual Property Rights<br>Another attempt to bring Māori values within a mainstream organisation, which subsequently disappeared. | In 1995 the Public Health Commission was disestablished and its functions were integrated into the Ministry of Health and Regional Health Authorities. The separate Māori public health section of the PHC was retained with in the Ministry and had six staff in 1997. In the year 2000 the number of staff specifically responsible for Māori public health is half of a position. It appears that the model was not picked up by other entities in the health sector. |

| Sector Change | Policy Milestone | Strategies and recommendations | Outcome |
|---|---|---|---|
| **1994** | Te Raranga Kete – A six question framework to assess components of the health reform process Te Puni Kökiri 1994. | The framework has similarities to the Hauora checklist with the addition of a more explicit question on Article III responsibilities of the Crown.<br>• How does the report assist the Government to improve the health status of Mäori so that in the future Mäori will enjoy at least the same level of health as non-Mäori?<br>• What recognition has been made of the factors that affect Mäori health status in the development of this report?<br>• What involvement have Mäori had in the development of the report?<br>• What ongoing arrangements have been developed for Mäori to be involved in the further development of this report?<br>• How effective is this report in promoting the development and maintenance of Mäori health initiatives to enable Mäori to take responsibility over their own health?<br>• How effective is the information gathering system used to ensure that Mäori health status is monitored, and how will this information be used? | It has been difficult to ascertain whether this framework was widely used or implemented in the health sector. |
| **1995** | A Mäori Policy Analysis Framework for the Ministry of Health, Keri Lawson Te Aho 1995. | "A way of developing policy that will assist staff in the Ministry of Health to incorporate a Mäori perspective into their policy work."<br>Another example of the use of external Mäori consultants to advise on the incorporation of Mäori values. The repeated nature of the advice suggests that it was largely ineffectual. | The Te Puni Kökiri review (1997, p6) found "only partial ownership ... and relian(ce) on Mäori health policy analysts" |

| Sector Change | Policy Milestone | Strategies and recommendations | Outcome |
|---|---|---|---|
| **1996** | The National – New Zealand First Government Coalition Agreement - a softening of the commercial focus of CHEs and RHAs | Improvements in Māori health status were identified as priorities.<br><br>In recognition of Government's commitment to improving the status of Māori health, increased resources will be made available to provide Māori leadership within the health sector and to enable the continuing growth and development of Māori health service provision by Māori (National - New Zealand First Coalition Agreement, 1996, p. 34, Coalition Agreement)<br><br>The key initiatives of Māori policy relevant to health included:<br><br>• Implement Ka Awatea as amended<br>• The development of the four Māori Commissions, including the Māori Health Commission, Māori Economic Unit, Māori Education and Māori Employment and Training Unit<br>• To review the representation (of Māori) on various government bodies (National - New Zealand First Coalition Agreement, 1996, p35) | The National-New Zealand First Coalition Agreement health policy encouraged the further development of Māori providers. The Article Two argument of "by Māori for Māori" was supported as it coincided with the governments thrust towards decreased dependency on the state and the encouragement of the development of private providers to compete in the market. |

| Sector Change | Policy Milestone | Strategies and recommendations | Outcome |
|---|---|---|---|
| 1997 | Mäori Health Commission | The role of the Mäori Health Commission as determined in its Terms of Reference required the Commission to:<br><br>• assist the Government in meeting their Strategic Result Area (8) for 1997-2000 by making "significant progress towards the development of policies and processes that lead towards closing the economic and social gaps between Mäori and non-Mäori",<br>• operate as "think tanks" by developing initiatives for accelerating Mäori development in education, health, economic development, and employment and training that can be grafted into the mainstream,<br>• assess the general progress of Mäori in each policy sector, monitor reports of other agencies and consider their implications as well as reporting on the progress of our own initiatives,<br>• coordinate, plan and provide advice to the Minister of Mäori Affairs in an interconnected and inter generational manner,<br>• manage the expectations of Mäori communities, relevant sector agencies and the public,<br>• provide advice and reports to the Minister of Mäori Affairs recommending changes to policies for Mäori development that will contribute to a reduction of disparities between Mäori and non-Mäori.<br><br>The Mäori Health Commission identified the priorities in Mäori health as:<br><br>• Mäori Mental Health<br>• Mäori participation in the Health Sector<br>• Mäori integrated care<br>• Rationing Systems and their criteria<br>• Mäori Health Authority<br>The Commission explicitly criticised the government for its focus solely on an Article 3 approach. "Mäori health is a priority only insofar as Government is required to act to equalise Mäori health status with that of non-Mäori" (Mäori Health Commission, 1998, p5) | The Mäori Health Commission was abolished by the incoming Labour – Alliance government in February 2000 |

From the recent policy development outlined in Table 6 above it is clear that the Crown and its agencies have been unable to apply a coherent framework to their own activities, let alone translate that action into health gain. The Ministry of Health has failed to model effective Treaty based relationships, and failed to ensure the primacy of the Treaty within its operations. The Health Funding Authority was unable to effectively influence mainstream providers in spite of a clear Mäori health gain policy. Crown health agencies failed to deliver health services to Mäori in a way that is consistent with the Crown's Treaty responsibilities. Relationships that were established with Mäori became disrupted through sector and agency change.

At times, Treaty policy has taken a very narrow interpretation. Crown responses to the Treaty and Health in the 1990s concentrated to a large extent on historical issues, and the process of settling grievances. This is clearest in instructions from the National Interim Provider Board and later from CCMAU reminding Crown entities of their the obligation to ensure that real estate that they held was available to Mäori as part of a settlement process, where they looked to dispose of such assets ( National Interim Provider Board, 1992 & CCMAU, Statement of Owners' Expectations of Crown Health Enterprises, March 1998).

### Who has been responsible for Developing Effective Mäori Health Policy?

The health sector reform of 1993 set out clear expectations of the Minister of Health in the Health and Disability Services Act 1993. The Minister was obliged to give written notice of the Crown's objectives in relation to:

> (a) Health status of the community served by the funder:
> (b) The health outcomes sought to be attained for the community served by the funder:
> (c) The health services or disability services, or both, to be funded by the funder:
> (d) The terms of access to those services; and the assessment and review procedures to be used in determining access to those services or such of those services as are specified in the notice:
> (e) The standard of those services:
> (f) The special needs of Mäori and other particular communities or people for those services (The Health and Disability Services Act 1993, Section 8)

Once the Minister issued the objectives, they were also required to ensure that the objectives were met.

> The Minister of Health is responsible to the House of Representatives for -
> (a) Monitoring the extent to which -
> (i) The purpose of this Act has been achieved; and
> (ii) The objectives of the Crown and the Health Funding Authority have been achieved; and
> The performance and exercise of the functions, duties, and powers given to him or her by this Act (The Health and Disability Services Act 1993, Section 12)

The Minister of Health's duties were clear. However, the same clarity could not be said to prevail in the rest of the sector as is revealed below.

## Reform effects, identities and roles

Health sector reform of the late 1980s and 1990s had the effect of multiplying and reconstructing policy with each change of government. As has previously been

noted, health structures were also regularly and periodically substantially changed. This changed the identities of various Crown agencies, and their roles, sometimes in more than subtle ways as displayed in Table 7and Table 8 below.

## Table 7: Health Entities 1983 -1997

| Entity | Description | Period of operation |
|---|---|---|
| Hospital Board: | 28 entities consisting of a wholly locally elected Board of community representatives responsible for hospital services in its electoral area. | 1885 to 1989, depending on date of replacement by AHB |
| Department of Health | The Government's chief policy adviser on health and provider of public (population) health services | Up to 1993 |
| AHB – Area Health Board | 14 distinct entities charged by the Government with both elected and appointed representatives with the responsibility for all health service delivery and health promotion within their defined geographic areas. | 1986 – 1993. |
| NIPB - National Interim Provider Board: | The Central Government agency created to oversee the transition from Area Health Boards into the split entities of Regional Health Authorities and Crown Health Enterprises. | 1991 - 1993. |
| PHC – Public Health Commission: | The funder of public health services (that is, population-based health services such as anti-smoking initiatives), previously funded by the Department of Health. Services rolled into the Regional Health Authorities in 1995. | 1993 - 1995 |
| RHA - Regional Health Authorities | Four health funding bodies established by the Government, with appointed Boards, to fund the health needs of their regions, North, Midland, Central, and Southern. | 1993 - 1997. |
| CHE - Crown Health Enterprise | 23 distinct State Owned Enterprises (usually based around one or more hospitals) with Boards solely appointed by the government, charged with providing health services to a local population, subsequently known as HHSs, Hospital and Health Services. | 1993 - 1998. |
| CCMAU - Crown Company Monitoring and Advisory Unit | The arm of the government that acted as the owner's agent in respect of Crown Health Enterprises. It monitored the CHEs' performance on behalf of the shareholding Ministers, and was an arm of Treasury. It was funded from the appropriations of those areas | 1993 – 2000 |

| | | |
|---|---|---|
| | of government service provision it was active in monitoring, with health making up approximately 50% of its revenue stream. Predecessors include CHEEU (Crown Health Enterprise Establishment Unit) and CHEMU (Crown Health Enterprise Monitoring Unit). | |
| MOH – Ministry of Health: | The replacement of the Department of Health as the Government's chief policy adviser on health issues. | 1993 – present. |
| Mäori Health Commission: | One of four Mäori Commissions established as a result of the 1996 National-New Zealand First Coalition agreement to address issues of Mäori inequity. | 1996 - 1999 |
| MHC - Mental Health Commission: | A commission established subsequent to the second Mason Enquiry into Mental Health Services, to oversee the impact of additional government funding of mental health services. | 1996 - present |
| HFA - Health Funding Authority | The single national successor to the Regional Health Authorities as Health Funder. It replaced the Transitional Health Authority, which in turn had replaced the four Regional Health Authorities. | 1998 – 2000. |
| HHS – Hospital and Health Services | The replacement name for CHEs. 23 in number, with 2 CHEs merging, and the formation of a national Blood Service HHS | 1998 – 2000. |
| NGO - Non Government Organisation: | Usually meaning a not for profit health or disability support service provider. | Significant factor from 1992 to present |

The result of the above ongoing changes has included community confusion over which section of the health sector is responsible for what, and confused accountability and control structures within the sector (Blank in Miller, 1997).

## Table 8: Summary of Health Sector Organisations

| Year of Creation | Local | Regional authority | National authority/ accountability |
|---|---|---|---|
| Pre 1986 | Hospital Board | No Entity | Department of Health |
| 1986 | Area Health Board (variously established 1986-1989) | Department of Health | Department of Health |
| 1993 | Crown Health Enterprise | Regional Health Authority (RHA) | Ministry of Health and Public Health Commission (PHC) |
| 1995 | Crown Health Enterprise | RHAs assume PHC role | Ministry of Health |
| 1997 | Crown Health Enterprise | Transitional Health Authority | Ministry of Health |
| 1998 | Health and Hospital Services | Health Funding Authority | Ministry of Health Mäori Health Commission |

# Fragmentation

### Who leads and sets the strategies?

Health and Disability policy development takes place within the framework of New Zealand's parliamentary democracy, led by the government of the day. Many state agencies, particularly those with coordinating functions across state sector boundaries, influence, guide and limit both the development and implementation of such policy. The State Services Commission, the Treasury and the Department of Prime Minister and Cabinet are the three central agencies in the New Zealand Public Service for providing leadership, coordination, and advice on the management of the State sector.

The recent change within the health sector has often concentrated on structural reform. These three agencies mentioned above can have a pivotal effect on

structural reform, and on the tension between achieving government policy outcomes and the cost of doing so. The leaders in Mäori health and disability policy development must therefore be seen within the constraints that can be imposed by these central agencies. While the agencies have not remained consistent throughout the reform period under study, many of the functions have persisted, though in differing guises.

### *Policy Development - The Leaders*

The government of the day is the key determiner of policy, as it operates with the electoral mandate to set the country's direction and governance. Three agencies, the Ministry of Health, the Health Funding Authority (1998 – 2000, now disbanded) and Te Puni Kökiri have played key roles in developing health and disability policy in respect of Mäori during the period of this study.

## The Ministry of Health

The Ministry of Health (and its predecessor the Department) has remained the principal adviser to the Minister of Health and to the Government on all health and disability matters including those pertaining to Mäori throughout the period 1983 - 1997 . The role of the Ministry of Health has remained consistently to:

- provide the Minister of Health and the Government with advice on policy for health and disability support services and on health implications of policies in other sectors;
- act as the Minister of Health's agent for administering public funding to the sector, negotiate funding agreements with purchasers and manage their performance;
- protect, promote and improve the public health, and report annually on the state of the public health;
- monitor the overall performance of the sector;
- administer health sector legislation and regulations;
- collect and disseminate national health information; and

- provide Ministerial and parliamentary information and support services (Te Puni Kökiri, 1997, p14)

The Ministry of Health's role applies to the wide variety of providers and purchasers in the sector, be they Crown health entities, non-government organisations and private sector organisations.

## Health Funding Authority (and its predecessors)

The Health Funding Authority (HFA) was formally established in 1998 as the centralised replacement body of the previous four Regional Health Authorities. The primary role of the HFA was that of purchasing services and ergo policy implementation. There is no doubt that it played an important role in policy development as well, as witness for example the Mäori Health Policy attached in Appendix 2 (HFA, 1998). The HFA's objectives were:

- To promote the personal health of people
- To promote the care or support for those in need of personal health services or disability services
- To promote the independence of people with disabilities
- To meet the Crown's objectives notified to it under section 8 of the Act--- in accordance with, and to the extent enabled by, its funding agreement (Health and Disability Services Act 1993, Section 10).

Its functions were:

- To monitor the need for public health services, personal health services and disability services of the people who are described for this purpose in its funding agreement
- To purchase public health services, personal health services and disability services for those people, by means of purchase agreements or otherwise
- To monitor the performance of purchase agreements or other arrangements by persons with whom it has entered into such agreements or arrangements
- Such other functions as it is for the time being:

- Given by or under any enactment;
- Authorised to perform by the Minister, by written notice to the authority after consultation with the authority (Health and Disability Services Act 1993, Section 33, as amended in 1995).

The Health Funding Authority was itself later "morphed" and integrated with the Ministry of Health under the reforms of the incoming Labour led coalition government in 2000.

## Te Puni Kökiri

Te Puni Kökiri was established under the Ministry of Mäori Development Act 1991. Its responsibilities under that Act included:

- Promoting increases in the levels of achievement attained by Mäori with respect to---
  1. Education
  2. Training and employment
  3. Health
  4. Economic resource development
- Monitoring, and liasing with, each department and agency that provides or has a responsibility to provide services to or for Mäori for the purpose of ensuring the adequacy of those services.

The Act specifically noted that the responsibilities of Te Puni Kökiri were not limited to the provision of the Treaty of Waitangi Act 1975

The role of Te Puni Kökiri was to provide high-quality policy advice on the Crown's relationship with iwi, hapü and Mäori and on the Government's objectives, interests and obligations relating to Mäori.

Strategic leadership advice includes:

- strategic policy advice to the Government on Mäori development issues and on the Crown's ongoing relationships with iwi, hapü and Mäori;
- monitoring the performance of mainstream government departments to assess the impact on Mäori of the policies they develop and administer, and give advice to departments on the design and development of monitoring systems for this purpose;
- facilitating consultation between the Crown, its agencies, and iwi, hapü and Mäori, on policies affecting Mäori, and the development of the relationship between the Crown and Mäori;
- informing Mäori that mainstream departments are responsible for designing and delivering policies, which meet their circumstances (Te Puni Kökiri, Post Election Briefing, 1999, p11)

Te Puni Kökiri must also provide advice on sectoral issues, as follows:

- alongside the principal mainstream departments, provide advice on the design and implementation of policy as it affects Mäori. This covers the four main areas of education, training and employment, health and economic resource development, including advising on inter-sectoral issues;
- comment on and contribute advice on other policies developed by mainstream departments that will satisfy government objectives in respect of Mäori;
- monitor and analyse outcomes and trends in the areas of importance to Mäori development, which are indicated in the Ministry of Mäori Development Act 1991. Te Puni Kökiri is to communicate these results to iwi, hapü and Mäori, and to work with other departments to develop and implement systems for improved performance;
- facilitate consultation between the Crown, its agencies, and iwi, hapü and Mäori on sector-specific policies and practices (Te Puni Kökiri, Post Election Briefing, 1999, p11).

In respect of local intervention and risk management, Te Puni Kökiri should:

- provide early warnings of local, discrete, issues that are likely to have a significant impact on the Crown-Mäori relationship and, where Ministers consider appropriate, move to resolve the issues;

- facilitate access, at a local level, by Mäori to mainstream service delivery agencies (Te Puni Kökiri, Post Election Briefing, 1999, p11)

*Policy Implementation – The Providers of Health Services*

## Health and Hospital Services

Health and Hospital Services were originally established as Crown Health Enterprises under the Health and Disability Act 1993. They assumed the HHS title after an amendment to that act in 1998. Their objectives were to:

- Provide health services or disability services, or both
- Assist in meeting the Crown's objectives under section 8 of this Act by providing such services in accordance with its statement of intent and any purchase agreement entered into by it--- while operating as a successful and efficient business
- To exhibit a sense of social responsibility by having regard to the interests of the community in which it operates
- To uphold the ethical standards generally expected of providers of health services or disability services, or both, as the case may be
- To be a good employer
- To be as successful and efficient as comparable businesses that are not owned by the Crown (Health And Disability Services Act 1993)

The latter objective was amended to requiring HHSs to operate in a business like manner, said amendment being widely seen as removing the profit motive as a driver of HHSs.

In the latest reforms (1999-2000), HHSs have become the base organisations from which the new District Health Boards have been created. They have become the "provider arm" of the DHBs.

### NGOs and Mäori Providers

One of the results of the 1993 Health sector reforms was a significant broadening of the non-government owned health providers. Many agencies that were previously voluntary or charitable entered funding contracts and have since become a significant part of the sector in their own right. General practitioners have grouped together into, in some instances, quite sizeable Independent Practitioner Associations. Mäori health providers have significantly increased in number, as noted elsewhere.

## Who Drives Policy Consistency? Inter-sectoral Structures and Relationships

### Overview

Many central agencies have had an influence on aspects of health policy within the period of this study. Their response to Mäori health issues and concerns and to the role of the Treaty of Waitangi in health is highly variable. Margaret Wilson, Associate Justice Minister, has been reported as describing the relationship between the Crown and Mäori as "highly shambolic, leaving the government open to legal action. She says that government agencies' inconsistent approach to Mäori, lack of expertise, and focus on past wrongs may give rise to a new batch of grievances (Sunday Star Times, May 28, 2000, p2)". The central agencies' response to Mäori health policy exemplifies this concern.

## The Ministry of Health

From 1993 onwards the Ministry of Health believed that its policies became effective through the actions of the Health Funding Authority, in contracting for services to meet needs and improve health status. The onus to consult the community rested with the Health Funding Authority in terms of the health legislation. The role of Te Kete Hauora, the Mäori advisory unit within the Ministry of Health, exemplified the development of policy in a pure environment, that is an environment with few linkages to the sector or consumers, largely limited to reference groups, specific issues focused hui, and personal networks, divorced from the effects of that policy on the health outcomes affecting Mäori.

### *Te Kete Hauora*

Te Kete Hauora was the Mäori Health Group in the Ministry of Health formed in 1993 as a catalyst to enhance the way the Ministry and the health sector responded to Mäori health needs. Te Kete Hauora was to be responsible for providing Mäori health policy advice to the health sector through the development of strategic policy analysis and advice. As a result of the Mäori Health Review (1993) conducted by Mason Durie and Hekia Parata the previously integrated Mäori health section was established as a separate group dedicated to Mäori health policy and led by a Deputy Director-General, Mäori Health.

The role of Te Kete Hauora has been described as maintaining a strategic focus on Mäori health. This included providing advice to Government, to ensure the Ministry of Health meets its Treaty of Waitangi obligations to improve Mäori health, the development of new policy and analysing key Ministry proposals.

Despite the 1999/2000 reforms and restructuring of the health sector Te Kete Hauora continues to function.

***Performance Management Branch: MOH***

Within the Ministry of Health, the Performance Management Branch (PMB) had the role of ensuring that the funder (HFA) delivered to the Minister and Ministry on the undertakings in its funding agreement. Those undertakings were often measured in terms of outputs (such as needs assessment, rationing, contracting, and contract-monitoring) (HFA Accountability Arrangements, Ministry of Health, July 1998). The PMB did not have a responsibility for Mäori health outcome. At the time of this research interview in mid 2000, only one-quarter of a full time position was allocated to the Mäori health accountability arrangements within the Performance and Monitoring Branch's overall brief. Performance was set and determined on the basis of contractual requirements rather than improved health outcomes. Audit and monitoring processes carried with them few sanctions and even fewer rewards. For example, the Ministry of Health report entitled Health Funding Authority Performance Report Quarter Three 1999/2000 (June 2000) concluded that the HFA did not achieve 7 out of 50 performance measures. In the area of Mäori Provider Development, which the Ministry considered "still considerably behind schedule " the sanction was to "monitor progress in this area closely" (MOH,2000, p vii).

*Sector perception of the Ministry of Health*[13]

Interviews conducted nationally in 2000 with a wide range of sector participants, both Mäori and non-Mäori, provided a series of common themes, illustrating the sector's perceptions of the Ministry of Health.

- The health reforms of the 1990s provided opportunities for leadership and the modelling of a Treaty partnership in action. However, this opportunity appears to have been lost.
- Provider perception is that their Mäori health initiatives had little to do with MOH policy or leadership.
- Their experience was that the Ministry of Health worked in isolation, did not "close the loop", and that they had or made minimal opportunity to establish the effect of their policy at local level.
- The Ministry of Health has never conducted a national review of Mäori health status
- "Policy occurs in a vacuum"
- "The distance of policy from the coal face, not a lot of bearing on what we do. Health policy is not a living document by the time it gets to the ground."

The Deputy Director General of Mäori Health has recently been reported as stating that the Government's Mäori Health Policy is the document Whaia te Ora mo te Iwi, (Ria Earp, Brief of Evidence, Waitangi Tribunal, Wai 692 Hearing, W16, 9 July 1999), published in 1992. Quite clearly, sector perception does not see this as relevant or current policy, and sees a failure on the part of the Ministry of Health to lead effectively in Mäori health. Further discussion on these issues follows later in this chapter in the section entitled Crown Owned Entities - Reflections on the Sector starting page 273.

[13] Themes arising from the interviews conducted with sector participants and agencies as detailed in the bibliography

## Health Funding Authority (and its predecessors)

The Health Funding Authority on its formation in 1998 had inherited four different approaches to Mäori health from the four Regional Health Authorities. It had supported improved Mäori health outcomes through continuing the development of Mäori health providers and the establishment of Treaty relationships. More latterly, it had begun the process of focusing on Mäori health gain through mainstream health service organisations. The HFA senior staff interviewed in the course of this research acknowledged that the HFA's ability to use contracting processes to deliver improved services to Mäori was significantly limited by wider political considerations concerning large mainstream health providers.

The Health Funding Authority developed a Mäori health policy specific to their role as purchasers in 1998. The purpose of the policy was "to identify and implement a proactive HFA response to Mäori health gain issues and development." The policy separated the ownership (internal) and performance (external) issues (see Appendix 2: Health Funding Authority Mäori Health Policy). The Health Funding Authority had implemented a matrix organisation, where the Mäori Health Group actively collaborated with the service operating groups to inform funding policy. Since 1999, the HFA required the providers with which it contracted to develop Mäori health plans. As the funder, the HFA had a very direct capacity to influence the growth of new Mäori health approaches, and change in the delivery of existing services. One issue that is critical in improving Mäori health is the number and adequacy of the Mäori health workforce. The

HFA, through its Clinical Training Agency, was in a position to influence workforce development.

***Sector perception of the Health Funding Authority[14]***

Interviews conducted nationally in 2000 for this research on the topic of the development and effectiveness of Mäori Health policy, with a wide range of sector participants, both Mäori and non-Mäori, provided a series of common themes, illustrating the sector's perceptions of the Health Funding Authority.

- No Mäori were included in the initial appointments to the Board of the Transitional Health Authority. The subsequent appointment of Wayne McLean required ministerial intervention.
- The HFA was perceived as having failed to use the contracting processes to effectively drive improved Mäori health outcomes
- No HHS has ever had any of its funding withheld for failure to deliver effective health outcomes to Mäori, even where the HFA (or predecessor) had known that the HHS was in breach of the Treaty.
- Personal relationships dominated the contracting for Mäori providers
- All HFA and RHA contracts had not consistently held Treaty specific requirements until the 1999/00 financial year
- Continual risk of loss of institutional memory and sector gains through restructuring.
- Loss of consistent information as the health sector undergoes frequent changes
- Consultation is at times perceived as inadequate or lacking, and has led to perceived disadvantage for some Mäori providers
- Staff of provider organisations interviewed viewed Mäori staff and the Mäori health group as having influence across the whole organisation
- Some providers are clearly out of favour in spite of the responsiveness of their organisation to meet the needs of Mäori.
- The dominance of the Iwi model has created barriers in some areas for urban and pan tribal initiatives
- Iwi providers have felt that they have not fitted the HFA Mäori health group model and therefore been disadvantaged
- Policy (all agencies) can lead to improved opportunities for Mäori staff within mainstream providers to improve health service delivery to Mäori.

---

[14] Themes arising from the interviews conducted with sector participants and agencies as detailed in the bibliography

Sector participants interviewed for this research perceived both the Ministry of Health and the Health Funding Authority as lacking the level of leadership the sector expected of these agencies in respect of Mäori Health.

### Te Puni Kökiri

Given the role of Te Puni Kökiri (TPK) as outlined in legislation, it might be expected that the monitoring of Crown entities (including Hospital and Health Services), their Treaty compliance and contribution to Mäori health gain was TPK's responsibility. This was not so. Te Puni Kökiri did not take a monitoring role at the local or regional level. Their focus was at the central decision-making level. The agency review process did not look at health provider level performance but was process focused. They were not involved in the monitoring of Hospital and Health Services.

> In the Ministry of Mäori Development Act 1991, Te Puni Kökiri is required to "monitor, and liaise with, each department and agency that provides or has a responsibility to provide services to, or for, Mäori for the purpose of ensuring the adequacy of those services". This has led the Monitoring and Evaluation Branch to focus on reviewing the policy advice, purchasing processes and decision-making processes in the public sector.
>
> CCMAU is responsible for monitoring HHS on behalf of the Crown, as owner of those companies (Lisa Davies, Letter to author - Clarification of Health Services Monitoring Roles, Te Puni Kökiri, Wellington, 1999)

The Memorandum of Understanding between Te Puni Kökiri and the Ministry of Health (unpublished internal memorandum, 1998) was interesting in respect of the limitations that it imposed on Te Puni Kökiri. Te Puni Kökiri was constrained by the MOU from developing systems outside the Ministry of Health's existing monitoring and public accountability activities that could impose additional, or duplicate existing, monitoring systems or costs within either the Ministry of

Health or the Health Funding Authority, without prior consultation with the Ministry of Health.

There was no agreed framework underpinning the collective working relationships between the three key agencies, MOH, HFA and TPK. While a formal framework of relationships and accountabilities existed, particularly with reference to appropriations, there was little that provided for day to day mechanisms promoting common goals with respect to Mäori health outcomes. Each of the agencies had an opportunity for leadership within the sector, yet they appear to have had no capacity to collaborate effectively on that leadership. The Ministry of Health required the Health Funding Authority to use the funding and contracting process to drive Mäori health gain through access and health outcome targets and service expectations in the Funding Agreement. Te Puni Kökiri, which had a memorandum of understanding with the Ministry of Health, evaluated the Ministry of Health on the effectiveness of its policy activities. Their 1997 review of the Minstry of Health is discussed in detail in the following section.

## What has the Crown's Health Sector Performance Been?

### How well has the Crown done as Leader?

It is instructive to consider how well the Crown views itself as having done in respect of Mäori health. The Ministry of Health and its predecessor the Department have been consistently criticised over the decade of the 1990s (Te Ara Ahu Whakamua,1994 and Ria Earp cross examination of evidence for the Crown concerning Napier Hospital Services Claim, Waitangi Tribunal July 30

1999, p122-132). Two separate examples of this criticism are given, on behalf of two Crown entities, and an external standard for performance is also given, that of the Controller and Auditor General's office. The criticisms reflect on the lack of leadership exercised by the Ministry in improving Mäori health and driving Mäori health policy. The examples demonstrate that the Crown has failed its own accountability tests let alone its accountability to Mäori as a partner under the Treaty of Waitangi.

*Mäori Health Review – Department of Health, 1993 (Parata & Durie)*

In 1993 the Department of Health was reviewed on how it could meet the Government's Mäori health objectives. The review, an assessment of the Department of Health's ability to be responsive to Mäori health, was prompted for several reasons. All the staff in the existing Mäori Health Unit had resigned and decisions about further appointments needed to be made. The future role of the unit, its functions and fit in the new Ministry of Health structure needed to be considered. The review was seen as timely by the Ministry of Health in order for it to meet the new legislative requirements giving effect to the changes in the health sector in the early 1990s.

The Government's principal Mäori health objective of that time was that: The Crown will seek to improve Mäori health status so in the future Mäori will have the same opportunity to enjoy at least the same level of health as non-Mäori (Policy Guidelines for Regional Health Authorities, 1995/1996).. The expectation was that the Department of Health as the Government's principal adviser and agent in the health sector would be delivering on the objectives. The review found that Mäori health was not a high priority in its corporate policies or practices.

The review demonstrated that the Department of Health needed to take immediate action and be more proactive.

> "the Department of Health has the principal responsibility for delivering on the Government's Mäori health objectives, and for monitoring and reporting upon the performance of the total health sector in this regard. The Department does not, at present, have the capacity to do this."
>
> "there is no provision within the various resource allocation processes that ensures that Mäori health gains are given priority, or indeed, are identified at all."
>
> "the Department needs to take urgent, substantial, and comprehensive action to resolve this situation. A critical mass of Mäori staff, and expertise in Mäori analysis and advice needs to be developed, along with a robust and serious role for Mäori participation in the achievement of Mäori health gains (Parata & Durie,1993, p15)".

The review again highlighted issues (see Table 6: Selected Milestones in the Development of Health Policy to Improve Mäori Health) that had been raised five years previously in Te Urupare Rangapu, (Dept. of Mäori Affairs, 1988); poor recruitment and retention of Mäori staff in the state sector, little participation of Mäori in decision making, unclear accountability of Crown agencies and their officials, and the inability of the mainstream to deliver to Mäori. Issues of leadership were raised in the review as being quite critical for the Department. They needed to lead the sector given their national role.

> While the other health agencies have their own statutory obligations, national coordination and a national overview will be of critical importance. In the absence of that wider context, and without strong leadership at a national level, goals for Mäori health run the risk of being reduced to a series of pragmatic objectives based primarily on the perspective of the organisation involved but without any coherence or links to the wider aims of Mäori development. The elaboration of a national picture must be the responsibility of the Department of Health. This is consistent with the vision of the Department to, among other things, " provide leadership within the health sector. We have a national role and will be seeking to enhance this" (Parata & Durie, 1993, p15)

Leadership had implications for the organisational structure within the Department. The review found that responsibility for Mäori health appeared to have been relegated consistently to the Mäori Health Policy Section and was not perceived as a department wide responsibility.

The review looked at the functions and roles of the organisation and where Mäori were located. Recommendations were made on the necessity of senior roles of leadership for Mäori within the organisation as well as increasing the numbers of core Mäori staff. It also recommended a Mäori graduate recruitment programme to increase the number of core staff in the Department of Health.

*Te Puni Kökiri, Review of the Ministry of Health Service Delivery to Mäori, 1997.*

In 1997 the Ministry of Mäori Development conducted a review of the Ministry of Health's internal processes for the provision of services to Mäori. The review contrasted the Ministry of Health's internal processes with those the Ministry of Mäori Development had developed for the wider state sector.

The 1993 review of Parata and Durie of the Department of Health was revisited. Progress identified since the 1993 review included the establishment of the strategic Mäori Health Group (Te Kete Hauora) and identifying Mäori health as a health gain priority. Despite improvements fundamental issues still needed to be addressed in the Ministry's Article Three responsibilities to Mäori and their ability to deliver on those.

> "(the Ministry has) not applied the various Mäori health frameworks throughout its operations"

> "the Ministry of Health as a whole has yet to accept full responsibility for promoting improved Mäori health outcomes" (Te Puni Kökiri, 1997).

The issues raised in the 1993 review of wider ownership of Mäori health gains throughout the Department were revisited and commented on. Staff in the Ministry appeared to be still reliant on the Mäori health policy analysts to achieve gains. This reliance interfered with the Mäori Health Policy analyst's ability to focus on their strategic role as they were frequently called on to fulfil an operational role.

The key finding of the Ministry of Mäori Development (1997) review was; " .... The Ministry of Health has yet to fully implement its strategies and frameworks for promoting Mäori health gains". Nine further points were made as to how the Ministry of Health could improve the Ministry's service provision for Mäori. While some of the issues were new, others had been raised in the 1993 review.

The Ministry of Health was found to have:

- not applied the various Mäori health frameworks throughout its operations. The Ministry of Health was currently refining its policy development process to include Mäori health frameworks;
- a need to promote greater involvement by non-Mäori staff in considering Mäori health issues to reduce the reliance on Mäori health policy analysts;
- not clearly communicated internally the role of Te Kete Hauora. Clarification of Te Kete Hauora's role may provide an opportunity for the Ministry of Health to better support and improve the effectiveness of Te Kete Hauora (Te Puni Kökiri, 1997).

The review clearly found shortcomings in the Ministry's ability to adequately prioritise Mäori health and raised questions on their commitment to Mäori health.

In 1994, the Ministry of Health had developed a responsiveness plan, Te Tatai Urupare ki te Mäori o te Manatu Hauora. The aim of the plan was to make the Ministry of Health the role model of a responsive organisation for the health sector. The findings of the Te Puni Kökiri review suggested this had not been achieved.

The review demonstrated the contradictions within both the state sector and health sector. While Mäori health may be a stated priority of the government of the day the Ministry demonstrated an inconsistent understanding of its Article Three responsibilities.

*Report of The Controller and Auditor General, 1998.*

In 1998 a report was released by the Controller and Auditor General's office, one chapter of which examined the Government's policy in relation to Mäori and reviewed Public Sector Organisation (PSO) performance and progress in achieving the policy expectations. The key feature of the policy in relation to Mäori was: " that improving outcomes for Mäori is the collective responsibility of the state sector. This emphasises the need for PSOs to be responsive to Mäori" (Controller and Auditor General, 1998, p76)

The report included an audit model that had been developed after consultation with Te Puni Kökiri, the State Services Commission, the Department of the Prime Minister and Cabinet, and the Treasury. Processes were identified that were expected that a PSO would follow when preparing outputs which would be effective for Mäori. These were; strategy, policy advice and service delivery, human resources, structure, and working environment.

The audit model provided a PSO with the opportunity for self-evaluation of their management processes to improve their service provision for Mäori.

The report outlined the Auditor General's expectations of the public sector and its ability to deliver effective outputs for Mäori.

> "We expect that a PSO's strategic planning process would:
>
> - Take account of the Treaty of Waitangi, and in particular the Crown's position on Treaty issues
> - Consider how to contribute to the Government's strategic goals with respect to Mäori
> - Identify potential Treaty issues
> - Involve Mäori as appropriate
> - Require coordination and cooperation with other organisations delivering related outputs to for Mäori
> - Include objectives in relation to Mäori, which translate into operational objectives and outputs to fulfil the government's strategic goals with respect to Mäori
> - Produce performance measures to assess progress towards strategic goals, objectives and outputs, and changes in outcomes for Mäori
> - Review and identify how to improve Mäori-related capability and outcomes for Mäori." (Controller and Auditor general, 1998, p80)

For the public sector to be responsive and meet the objectives the report outlined several factors that needed to be considered including:

> Government's Strategic Goals -
>
> The strategic planning process requires a PSO to consider a range of influences on its work. For example:
>
> - Cabinet decisions on Te Puni Kökiri's medium to long-term role
> - Compliance with legislative requirements such as section 56(2)(d) of the State Sector Act 1988and sections 6(e) and 8 of the Resource Management Act 1991

- Case law relating to the Crown's responsibilities under the Treaty of Waitangi
- The reports and findings of the Waitangi Tribunal ... and the Government's response
- Government policy in respect of the Treaty and associated issues
- Advise from Te Puni Kökiri as a monitoring and advisory agency
- Guidelines produced by the State Services Commission such as "Towards Responsiveness" and Partnership Dialogue."
- Expectations of iwi and pan-tribal groups
- Mäori demographics and future trends...
- Potential future scenarios for Mäori in New Zealand.

Identifying Potential Treaty Issues:

A PSO should consider how its role and functions relate to the Crown's obligations under the Treaty of Waitangi, and how the PSO could contribute to meeting those obligations. For example, it needs to consider whether its activities might affect rangatiratanga (control) over resources and taonga (Article Two) or influence the degree of quality of access by Mäori to services, which affect equity of outcomes (Article Three).

A PSO also needs to reflect accurately the collective Crown position on these matters.

Involving Mäori in the Planning Process;

A PSO might need to involve Mäori to test the assumptions and priorities in the strategic planning process. For example, a PSO might draw on the views of a previous consultative hui or it might build long-term relationships with people who can represent Mäori perspectives.

The strategic planning process might also allow for input from Te Puni Kökiri, which has significant relationships with all departments and provides advice in the areas of most concern - such as justice, education, health, and employment (Controller and Auditor general, 1998, p80,81)

The report recognised that the strategy of a PSO needed to be translated into action plans and recommended plans should include:

- Objectives for recruiting Mäori.
- Support for Mäori employees.

- Skills relevant to understanding Mäori society and values.
- Procedures to take account of Mäori perspectives.
- Assurance about compliance with legislation, case law and best practice, in relation to Mäori (Controller and Auditor General, 1998, p82)

The report provided clarity on what the responsibilities and expectations are on the state sector. The Government objectives were outlined together with how these could be incorporated into organisational strategic plans. Public Sector Organisations had a responsibility to meet Government objectives and Treaty principles and this was explicitly stated.

The report provided a detailed framework so that an organisation could implement the strategy to ensure it was as responsive to Mäori as possible. If an organisation could implement the framework then this would actively contribute to the Crown meeting Article Three responsibilities. The report clearly recognised the Treaty responsibilities on the Crown and attempted to provide a cohesive approach for the entire state sector to ensure consistency.

The Ministry of Health since 1998, however, has given no indication that it or any other Crown Owned Health entity has audited itself against the processes spelt out in the Auditor General's report. Clearly, the examples given in other parts of this section indicate that such an audit carried out now would be unlikely to produce consistently positive results.

*The Crown as Owner: CCMAU*

## Crown Company Monitoring and Advisory Unit (CCMAU)

CCMAU was established in 1993 to provide the Government with information on the performance of a range of Crown companies (HHSs, Crown Research Institutes, and State Owned Enterprises), as well as advice on how to maximise the benefit of the Crown's ownership of those companies.

CCMAU described their role as being "to advise shareholding Ministers on the balance between public policy objectives and efficiency objectives, and identify trade-offs between them" (CCMAU, 1999, p8). Their core objective as stated was "to provide advice that protects and enhances the value of Crown companies" (CCMAU, 1999, p3).

The ownership relationship between the Crown and Health and Hospital Services sat with two Ministers, the Minister of Finance and the Minister of Health, and was exercised through CCMAU. The accountabilities and reporting relationships were highly complex. CCMAU described itself as an independent unit administratively attached to the Treasury.

CCMAU focused on

- The formation, structure, investment and continued ownership of individual companies
- Business strategy and the associated risks and opportunities
- Ensuring the most qualified directors were recommended for appointment

- Performance, in absolute terms against objectives and relative performance against benchmarked companies
- The impact of government policy and regulation of individual companies or groups of companies
- Innovation best practice and continuity of services

CCMAU set out the range of strategies to influence the health sector available to the incoming 1996 Government as follows:

- Setting the total level of health funding
- Determining how and at what level rationing will occur
- Introducing competition through allowing multiple purchasing
- Legislating change or negotiating protocols (CCMAU, 1996, p9)

Direct influence on CHEs could be exerted through:

- Appointments of Chairs and Boards of CHEs
- Setting performance targets
- Removing non-performing Boards, allowing mergers, takeovers etc
- Establishing pressure through targets
- Reporting requirements
- Meeting or writing concerning performance
- Disallowing borrowing
- Encouraging benchmarking
- Advocacy, including highlighting successes
- Publicly explaining poor performance and any remedial action taken (CCMAU, 1996, p9, 10)

CCMAU was the entity that carried out these activities on behalf of the Ministers.

The Crown established its expectations of its business entities through annual statements of owner's expectations. Those formed the matching half of the accountability framework to the CHE/HHS annual statement of intent.

Throughout most of the 1990s, the SOE documents to CHEs and HHSs have

contained little or no reference to Mäori health gain as a government priority, or to the special relationship of Mäori with the Crown as based on the Treaty of Waitangi. Those few references to Mäori, and Mäori health that existed, were of a relatively marginal nature. For example, the March 1998 Statement required Boards of CHEs:

> In disposing of surplus facilities, ... ensure that you comply with the surplus asset disposal requirements, including;
>
> - the relevant protection mechanism which addresses the Crown's obligations under the Treaty of Waitangi, and good governance over Mäori sites of significance

It further noted that CHEs were also required by the Health and Disability Services Act (1993) to:

- assist in meeting the Crown's objectives under the Act, which include the special needs of Mäori for health and disability services.

This change appeared to reflect the government policy changes brought about as a result of the 1996 National-New Zealand First Government Coalition agreement, and specifically the advice to the government on implementing that policy (Steering Group, Ministers of Health, 1997, p54).

The monitoring role of CCMAU was limited to ensuring that the relevant health entities were fit to carry out whatever function they were required to do by contract together with the limited monitoring of other numerical or fiscal criteria. CCMAU was not required to monitor the actual health output of any Crown entity. CCMAU has no formal or indeed statutory role in the health system in any event.

> Q. Does CCMAU have a role in monitoring - I think you call it, the key accountability documents, which you've set out in paragraph 17 of your evidence. Does CCMAU have a role in monitoring that those key accountability documents properly address Mäori Health needs?
>
> A. Not in relation to these particular documents, but I will answer the question in relation to the documents that –
>
> Q. So, just - yeah, just in relation to these particular documents?
>
> A. In relation to these particular ones, no. The Ministry would be responsible for 17.1 through 3. The financial statements, annual reports, are subject to Audit Office scrutiny. Naturally, we'd be aware of these documents; we don't formally monitor the documents (Chris Clark evidence for the Crown concerning Napier Hospital Services Claim, Waitangi Tribunal July 29 1999, transcript p32)

For the period of the study there were no arrangements by CCMAU to include Treaty obligations within the ownership expectations imposed on Crown Health providers by the Crown. It was not until 1999 that the Mäori Health Commission developed policy with CCMAU to include Treaty-based obligations in the annual set of expectations. The 1999 Statement of Expectations from the Shareholding Ministers referred for the first time to principal objectives and performance expectations of HHSs for Mäori health (see Appendix 1: CCMAU Treaty Obligations in SOE). Both of these entities were swept away in the subsequent 1999 Labour-Alliance coalition government health reforms. CCMAU became absorbed into the Ministry of Health as the Sector Funding and Performance Directorate in the most recent (1999/00) restructure.

Until the Crown as primary owner of the health sector providers (not funder/policy maker) rated Mäori health gain as a priority for those of its agencies that could effect it, and thus signalled it as a priority to the rest of the sector, the

gap between rhetoric, policy, and practice was highly explicable. In that circumstance, policy was truly in a vacuum, talking to itself.

### *Crown Owned Entities – Reflections on the Sector*

To gain an understanding of the impact of central policy and how policy was translated and implemented at the regional level management staffs of five HHS's were interviewed (Crown Health Association, Auckland Healthcare, Canterbury Health, Capital Coast Health, Northland Health, Pacific Health, April - June 2000). They included staff from Chief Executive level to Managers of Mäori health units. To ensure balance the HHS's ranged from urban and rural service provision, included North and South Island services, both high and low density Mäori populations, and services that provided for large populations and smaller providers covering a large geographical area. Despite the variety there were consistent themes in the comments made.

The most constant and universal criticism was the perceived lack of leadership on Mäori health issues throughout the 1990 reform period by central agencies, particularly the Ministry of Health. HHS's had no sense of there being a "big picture" for Mäori health such as a national strategic plan or direction that every entity in the health sector implemented consistently.

Policy from the Ministry of Health and the Health Funding Authority was described as not clearly articulated by most interviewees. One southern HHS stated they had never sat down with the Health Funding Authority to specifically discuss Mäori health. Surprisingly, they also were not aware that the Southern

Regional Health Authority's strategy for Mäori health was mainstream enhancement.

It is not surprising that there was inconsistency of approach if Crown owned service providers were not aware of the key Mäori health strategies. How could they ensure they were delivering on stated Crown priorities? Consequently good initiatives tended to be isolated, individual and, in spite of, rather than because of central policy.

Some interviewees identified the degree of support at HHS governance level for Treaty responsiveness as a critical success factor in developing Mäori health strategy. One HHS interviewee stated that the relationship with Iwi and subsequent model they were able to develop was possible due to the Board having a strong understanding of their governance role in the Treaty relationship. The understanding of Treaty partnership at the governance level provided the CEO with the support required to implement change so the organisation could be more responsive to Mäori.

One HHS participant stated that unless there were key government documents, such as the Crown Statement of Owners Expectations and the Health Funding Authority National Strategic Mäori Health Plan, Mäori management staff would not have leverage within the organisation to improve responsiveness to Mäori.

The reality for HHS's was that Mäori health developments have occurred to some extent in a policy vacuum, where business imperatives rather than policy

imperatives had prevailed. The effective initiatives implemented by HHSs occurred in spite of Mäori health policy, not because of it. Of the 5 HHSs involved in this study only one described key Crown policy documents as being influential on the initiatives they attempted to implement.

The Chief Executive of one HHS disclosed that their wide ranging initiatives to improve their responsiveness to Mäori had not been in response to central policy directions, and had not been resourced by the Health Funding Authority as they had not rated it as a priority to fund. An HHS that was trying to be innovative and responsive felt it was not actively encouraged to deliver on a stated government priority. Lack of clarity, lack of leadership and lack of consequences for other HHSs that were found to be in breach of the Treaty of Waitangi compounded the lack of incentives to innovate.

One urban HHS Mäori unit providing strategic advice to their Board and Chief Executive commented on the standard cultural model in HHSs, as having been the Kai Awhina who provided active emotional and practical support for the individual client and whanau. However, that model provided little challenge or influence at the organisational leadership level.

### How well has the Crown done as Funder/Contractor?

The Crown as funder and hence contractor is predominantly a feature of the 1990s health sector reforms under study. The funder/provider split established in 1993 has been identified by the Crown as a key accountability mechanism to ensure its objectives are met (Health and Disability Services Act, 1993).

> The responsibility of the Minister of Health is, obviously, to ensure that the funder spends its money wisely, essentially, and gets value for dollar in terms of health gain, given that we can't meet all health needs, and certainly I think that's been the critical issue about the reforms.
>
> Prior to separation of purchaser and provider, services were provided from hospitals really on what the hospital thought they should do. The purchaser has to provide a range of services, not just from hospitals, but for primary care and any other initiative, such as Mäori Health providers that we've heard about, to really put the money where the purchaser, or funder, thinks they will get the best health gain. That doesn't necessarily mean that traditional - the way medicines have been traditionally provided necessarily does that (Colin Feek evidence for the Crown concerning Napier Hospital Services Claim, Waitangi Tribunal July 29 1999, transcript p94)

The Crown from 1993 placed a high level of expectation on the funder to deliver Mäori health status improvements through:

- Consultation with Mäori communities
- Identifying Mäori health need
- Monitoring the provision of service to Mäori communities by contracted providers

The second Whaia Te Ora Mo Te Iwi (MOH, TPK, 1993, p15-17) document set out these expectations of the funders in some detail in the Mäori Health Purchasing and Contract Strategy - Key Requirements section. Consultation included requirements to be involved in all aspects of purchasing plans, development, implementation, review, and monitoring. Purchasing plans were required to be specific in respect of Mäori health needs, prioritisation processes, and the development of performance and monitoring standards.

Health service utilisation data was to be provided, and the methodology and timeframes to obtain such data to be spelt out. Lastly, the demographic factors impacting on service purchase requirements were to be identified, and the funder

was specifically required to "consider the socio-economic and cultural factors which deter Mäori from using health services in accordance with their health needs." (MOH, TPK, 1993, p17)

> The collection of Mäori health information will need to be sufficiently comprehensive to ensure that effective monitoring of the government's objectives is possible if under purchaser and provider levels. It is understood that the development of these health information systems may not be completed until after the 1993/94 transition year (MOH, TPK, 1993, p17)

To remove any doubt as to the obligations of the funder to consult with and monitor the needs of Mäori, these obligations were repeated in sections 33 and 34 of the Health and Disability Services Act 1993 and maintained with minor changes following the 1997 reform. Section 33 included requirements that the funder monitor the performance of the purchase agreements of those entities with which they contracted.

Crown evidence given in cross-examination during the Wai 692 claim showed how far the funder fell short of the requirements placed upon it by the Health and Disability Services Act 1993. During this time Mara Andrews was a policy analyst and subsequently a Manager of Mäori health in the Central Regional Health Authority (CRHA) and the Health Funding Authority.

> **MR POWELL (Counsel for the Claimants, Wai 692):** I'm sorry. It's fair to say that the CRHA did not take a proactive leadership role in trying to ensure participation through all the levels of the mainstream services?
>
> **MS ANDREWS (Mäori Health Manager, Health Funding Authority):** No, I don't think we didn't take a proactive leadership role; I think, we didn't know what Mäori expectation was, as to how they wanted that policy implemented. And, until we went out and consulted and had, you know, got into getting out and about and hearing from people, it was no good us trying to put things in place that defined how policy was to be implemented until we heard how they expected it to be implemented.

**MR POWELL:** And the net result of that was that, there wasn't any - you weren't able to make any moves, or any serious moves in increasing that participation --

**MS ANDREWS:** In that early year.

**MR POWELL:** -- because you didn't have that information?

**MS ANDREWS:** Yeah, in 93/94 we could not come out with any definitive implementation policies, or plans on how to implement Whaia te Ora mo te Iwi until we went out and talked to everybody about what their expectations were. So, the intent was, what we can do in this early year, this first year of business, is to go out and consult, put some money aside to extend some initiatives; and then, when we know what people's expectations are, then we can start putting in place some criterias and plans and things like that, which is why the three year strategic plan didn't come out until the following year, because that's when we heard it all, and that's when we could start firming things up.

**MR POWELL:** And, do you think you would have been able to have started trying to implement Te Whaia te Ora a bit more quickly, if you'd had more funding to be able to go out and send teams out to consult, to find out what Mäori wanted?

**MS ANDREWS:** Umm, if we had more people? I don't know. Well, maybe we could have. I think it - well, even if we had more people - I mean, there was only two of us in the Mäori Health Team at the time, and we had our Kaumatua Group, and let's say there was six of us; I think, still the same six would have gone to the same places, because we all needed to hear what it was people wanted out of the Health System. There was just nothing documented about any prior consultation on Mäori Health and where it should go to give us a lead, or a starting point, or anything. So, I don't know if more people would have had time. I couldn't answer (Mara Andrews, evidence for the Crown concerning Napier Hospital Services Claim, Waitangi Tribunal July 30 1999, transcript p203).

The two people identified in the transcript quote were responsible for Mäori health for all of the lower North Island and Nelson/Marlborough in the South Island. Mara Andrews had never been involved in health before the time she referred to and learned about the health issues on the job, having come from a background in the Mäori Land Court, Trust Office and Mäori Affairs Department (HFA, Sept 1998, p4, & Mara Andrews, evidence for the Crown concerning

Napier Hospital Services Claim, Waitangi Tribunal July 30 1999, transcript p204).

It was over three years from its inception in 1993 before the Central Regional Health Authority undertook a review of Healthcare Hawke's Bay's performance in respect of its services to Mäori. No follow up action in respect of the review's recommendations had occurred by the time of the Wai 692 hearing in 1999. At the hearing, Mara Andrews acknowledged that no action appeared to have occurred in respect of Healthcare Hawke's Bay's breach of its funding contract.

> **MS ANDREWS:** No. What I'm saying is, if we get to the point where we're writing letters to all our providers "you're in breach and that's it", sort of thing; what it's not considering, is the developing nature of both organisations. You know, we - these aren't the only things that any CHE is required to do; they're required to do hundreds of things to meet their contract obligations, and in their relationships with us they develop time lines around - the capability of them to meet those and we know, in all reality, they're not going to meet every single condition in a year. What we're doing is putting the stake in the ground saying, "these are the measures that we are expecting providers to meet".
>
> Now, providers have to develop a plan to meet them and agree a time line with us. And, the same happened with Mäori providers; they were given standards to meet too, none of them would have met them in the first year, none of them would have met them in the second probably, because they all needed time to develop and put systems and processes and learning paths in place.
>
> So, the environment wasn't as rigid as saying, "we've whacked some clauses in a contract, now you just do them or else". The environment was one where we had to try and be as clear as we could about expectations, and then allow our providers to develop to meet them. But, if we're going to insist "you do it now or breach", then I think we would have run into some very bad relationship management issues.
>
> **MR POWELL:** So, what you're saying is, really, the realities have got in the way of this arm's-length funder-provider model?
>
> **MS ANDREWS:** No, it's not - it's because it's - the realities of a developing sector are that, you cannot, in reality, expect developing providers to have everything in place from day one. And that, we knew CHEs and Mäori providers and others had a learning curve and a

development process to go through, to learn what the expectations of a purchaser were and how to put quality systems in place; just as they knew that we were learning to be a purchaser at the same time.

So, we just both lived with the reality that this was all new, and we were both learning, and to start slapping breach things on each other would have just been counterproductive. It was better to say, well - and I think this is what happened is, meetings I had with Mäori providers, and they would go through the contract and say, "Well, we've looked at this thing and how to implement it, and we don't quite know how, and are there any models for it". And we'd say, "Well, this other Mäori provider tried this, why don't you try that". And I just keep going back to the fact, there was no previous model for it, so everybody was learning, and learning to put in place standards like this as well.

**MR POWELL:** Just, what was the time line that was given to Healthcare Hawke's Bay to implement its Treaty policy?

**MS ANDREWS:** From memory, we said we would re-audit in two years.

**MR POWELL:** That's two years from December?

**MS ANDREWS:** From that financial year, which is why - and I think, had we stayed as a Central RHA, the cycle would have naturally come around; but with the restructuring and merger to HFA, some of the things that Central RHA had planned, had to be, sort of, merged into national processes. So, there is a national audit, cultural audit, planned of the CHEs this year, and we've simply sort of got woven into audits that other areas were planning themselves (Mara Andrews, evidence for the Crown concerning Napier Hospital Services Claim, Waitangi Tribunal July 30 1999, transcript p218)

So an audit that happened three years after the early 1990s reforms was due to be rerun two years later, by which time the Crown entity carrying out the review had already been phased out of existence. A clear example of the way that ongoing restructurings have hampered the continuity of policy and monitoring processes.

By 1998/99, after the period of this study, the Health Funding Authority had established a clear Mäori Health policy that was Treaty based (see Appendix 2: Health Funding Authority Mäori Health Policy). However, like its contemporaneous organisations, the HHSs and CCMAU, by the time such

policies were able to drive decision making, the HFA had joined the ranks of other restructured Crown health entities.

## The Resource Management Act - A marked contrast

The radical nature of the 1990s reforms in the health sector was matched by the reforms of environmental resource management. However, the incoming National Government 1990 could not sweep away local government structures with the same degree of ease they could abolish the Area Health Boards. The Resource Management Act 1991 created a redefinition of roles and responsibilities for how the sustainable management of natural and physical resources would be carried out. The Act provides a model of how the Crown has in the context of resource management established a process that was more inclusive and consultative than any prior legislation. It is in stark contrast to the health sector where radical change was imposed with little interaction or dialogue with the community and was perceived by many (Blank, 2000) as excluding rather than including.

The Resource Management Act was enacted in 1991 after a very comprehensive consultation process. The lengthy consultation process had been to provide more opportunities for public participation in shaping policy for environmental management. The environmental reforms began with a national 'Environmental Forum', held in 1984, to which a large number of community groups were invited. Continuing public deliberation followed up the Environmental Forum.

> Following the forum, a working party was appointed to advise government on the restructuring of New Zealand's environmental administration. This group toured the country, holding numerous public meetings. As a result, two new government agencies were created, to provide policy advice

(Ministry for the Environment) and conservation management (Department of Conservation). The government then set about reviewing all environmental legislation, replacing over fifty statutes with a single piece of legislation, the Resource Management Act (1991) (RMA) (Miller, 1997, p14)

The three-year lead-in to the RM Act itself involved a wide-ranging consultation process involving public meetings, public information campaigns and free phone-ins. The consultation strategy clearly reached a wide audience as it generated 3500 submissions. The RMA was viewed favourably as it provided greater opportunity for public participation in environmental management. Among the significant provisions of the RMA are: new procedures for extending public consultation through pre-hearings, hearings, and environment court; a wider definition of who may make a submission on resource consent, to include people with an interest in a planning issue, as well as those directly affected by it.

Table 9 sets out some of the provisions in the RMA. The significant contrasts with the contemporaneous health legislation include specific reference to the role of the Treaty of Waitangi, and consultation requirements of some depth and specificity. By comparison, health legislation of the same time period had some consultation requirements of the funding entities, and none at all of provider entities.

## Table 9: Resource Management Act Provisions

| |
|---|
| Section 8 - Treaty of Waitangi<br>In achieving the purpose of this Act, all persons exercising functions and powers under it, in relation to managing the use, development, and protection of natural and physical resources, shall take into account the principles of the Treaty of Waitangi. |

First Schedule - Preparation and Change of Policy Statements and Plans by Local Authorities

3. Consultation

(1) During the preparation of a proposed policy statement or plan, the local authority concerned shall consult

(a) The Minister for the Environment; and

(b) Those other Ministers of the Crown who may be affected by the policy statement or plan; and

(c) Local authorities who may be so affected; and

(d) The tangata whenua of the area who may be so affected, through iwi authorities and tribal runanga.

(2) A local authority may consult anyone else during the preparation of a proposed policy statement or plan.

Fourth Schedule - Assessment of Effects on the Environment

1. Matters that should be included in an assessment of effects on the environment

Subject to the provisions of any policy statement or plan, an assessment of effects on the environment for the purposes of section 88(6)(b) should include

(a) A description of the proposal:

(b) Where it is likely that an activity will result in any significant adverse effect on the environment, a description of any possible alternative locations or methods for undertaking the activity:

(c) Repealed by s225 RMAA 1993

(d) An assessment of the actual or potential effect on the environment of the proposed activity:

(h) An identification of those persons interested in or affected by the proposal, the consultation undertaken, and any response to the views of those consulted.

(i) Where the scale or significance of the activity's effect are such that monitoring is required, a description of how, once the proposal is approved, effects will be monitored and by whom.

2. Matters that should be considered when preparing an assessment of effects on the environment -

Subject to the provisions of any policy statement or plan, any person preparing an assessment of the effects on the environment should consider the following matters:

(a) Any effect on those in the neighbourhood and, where relevant, the wider community including any socio-economic and cultural effects:

(b) Any physical effects on the locality, including any landscape and visual effects:

(c) Any effect on eco-systems, including effects on plants or animals and any physical disturbance of habitats in the vicinity:

(d) Any effect on natural and physical resources having aesthetic, recreational, scientific, historical, spiritual, or cultural, or other special value for present or future generations:

(f) Any risk to the neighbourhood, the wider community, or the environment through natural hazards or the use of hazardous substances or hazardous installations (Resource Management Act, 1991)

The RMA provides a clear definition of the roles and responsibilities and processes for decision-making in environmental planning. The purpose of the Act was to promote the sustainable management of natural and physical resources. 'The net effect of the purposes and principles of the Act is to provide a formal framework against which standards, policy statements and plans can be formulated, and development proposals (consents) evaluated.' (New Zealand Institute of Local Government Managers, 1992) The Act provided and defined the hierarchy of decision-making as national, regional and district:

> *Central Government*: overview; policy development; performance and quality standards; national policy statements; mineral allocation; aspects of coastal management; management of hazardous substances.
> *Regional Councils*: overview/coordination; regional policy statements; regional plans (optional); water and soil management; management of geothermal resources; natural hazards mitigation/planning; regional aspects of hazardous substances; pollution management and air pollution control; aspects of coastal management.
> *Territorial Councils*: district plans; control of land use and subdivision: noise control; control of natural hazards, avoidance and mitigation; local control of hazardous substances use (Boston, 1996, p170)

This has provided clarity of structure, roles and function in contrast to the lack in the health sector over the same period. The RMA defines at the Central agency level the government's principal role is oversight and supervision. Functions formerly the responsibility of departments are now devolved to local government. A key difference between resource management legislation and health sector has been the definition and the allocation of monitoring functions. For the last decade monitoring has not been the allocated responsibility of any single agency in the health sector, but split amongst many. So CCMAU monitored the financial matters, and protected the shareholding Minister's interests. It did not consider its brief extended to Treaty monitoring, in spite of its name.

The effect of Crown fragmentation is evident in the response of the Mäori Health Manager of the HFA, when questioned in the Wai 692 hearing:

> **MR POWELL (Counsel for the Wai 692 Claimants):** But, just in terms of the consultation itself; at that time, in mid-1994, you would have been aware of the consultation that was, say, being undertaken in terms of the Resource Management Act. Have you looked at all of that and what constituted good consultation under that Act? Is that something that --
>
> **MS ANDREWS (Mäori Health Manager, Health Funding Authority):** I personally didn't, no.
>
> **MR POWELL:** Do you know if anybody else in the Mäori Health Group did?
>
> **MS ANDREWS:** No, we took a line - we didn't look at any other Acts for guidance on consultation; we took the advice of the Mäori advisors we had, which was to go out and have hui on marae and get around as much as you could, and listen to what people said. And so, the planning for this one, the May hui, if I remember, was actually to have that hui to see what the issues were and how big they were, and what things people might say, and then to take it from there (Mara Andrews, evidence for the Crown concerning Napier Hospital Services Claim, Waitangi Tribunal July 30 1999, transcript p203)

## RMA : Contemporary Criticisms

While public participation processes were strengthened in the RMA, more public participation does not necessarily mean greater public influence. Increased participation is valuable yet critics of the RMA have commented that participation occurs in a reactive manner usually through public submissions. A major limitation on effective participation has been access to resources.

> Preparing submissions or attending planning hearings and appeals is a costly, time-consuming, complex process. Those citizens, iwi and community groups who lack access to legal advisers, expert witnesses, photocopiers or telecommunications are heavily disadvantaged. At present there is no form of legal aid which might assist impoverished groups to

> prepare cases. In contrast, citizens and organisations who stand to make tangible financial gains from planning decisions, such as business interests and developers, are often highly motivated, comparatively well funded and consequently advantaged in the planning process (Miller, 1997, p415)

While the Resource Management Act has its drawbacks, the consultation model it provides warrants consideration as a potential template to be considered across all government agencies. A fundamental contrast to other examples of recent reforms across the public sector is that the RMA provides a process that allows Mäori the opportunity to participate in decision-making, and work in partnership with local government. Consultation and participation are seen within the Act as valuable in and of themselves, almost as though the opportunity to arrive at a public consensus might be considered a public good.

The RMA model recognised Mäori cultural and spiritual values and demonstrated they could be incorporated in legislation for contemporary issues. Section 8 of the RMA commits to upholding the principles of the Treaty of Waitangi and binds all those exercising functions under the Act to take into account the principles. The RMA is more specific in its recognition of the Treaty and the value it placed on Mäori cultural and spiritual values, in contrast with the health sector legislation of 1993 and 2000.

### Policy leads to progress?

The reality of policy implementation and monitoring through the reforms of the health sector of the 1990s has been the increased fragmentation of accountability. The delineation of roles and responsibilities within the health sector became

confusingly complex. Then it is not surprising there was a lack of any mechanisms to tell the government how the reforms were working. The Ministry of Health was never able to implement an accountability system that would give the government that level of information. There was therefore no feedback loop in place to advise the Crown of the impact of its policies and decisions on Mäori health.

> **MR POWELL:** In terms of the core accountabilities, what you're talking about is, as you say, the legal documents that link these different organisations, including the contracts?
>
> **MS EARP:** It links the different elements, like the Health and Disability Sector, yes.
>
> **MR POWELL:** Now, I think you'd agree, and I think you perhaps touched on it before, that across the Health Sector, across all these entities that you've listed in paragraph 13, there's no overall - no single entity that is in direct control of all of those entities that you've listed?
>
> **MS EARP:** There is not - the Health and Disability Sector is not set up in terms of command or control type structures; that would be correct. The Ministry of Health does provide an overview, there are these mechanisms in place to clearly outline the expectations of different parties and different groups within the Health and Disability Sector.
>
> **MR POWELL:** But, as you said before, the Ministry then relies on everybody else down the food chain in carrying out their tasks?
>
> **MS EARP:** That is correct (Ria Earp evidence for the Crown concerning Napier Hospital Services Claim, Waitangi Tribunal July 30 1999, transcript p146)

In other words, the Crown has promulgated policy, but has never put in place an effective feedback loop to monitor and ensure policy drives health service change. Effectively policy was developed and promoted as the government's position and each entity under the Ministry of Health was free to interpret and implement as they wished. The Deputy Director General of Mäori Health acknowledged in the above statement that it is not the role of any Crown agency to take overall

responsibility for the health sector. This highlights a flaw within the Crown strategy, in that, it is not enough to make Mäori health a priority and hope the rest of the health sector agrees with you and implements accordingly.

This chapter has outlined the policies and strategies of successive governments from 1983 to 1997 to address Mäori health. It has attempted to establish what the Crown's position has been and then examined whether the Crown has met its own expectations of the health sector. The Crown's own reviews have demonstrated the flaws in the health sector and established the shortcomings of its own monitoring processes. This chapter has attempted to demonstrate that the Crown by its own policy and accountability tests has been in breach of its Treaty of Waitangi obligations to Mäori.

# CHAPTER 8 - CONCLUSION

## What Now - How will Mäori Health Outcomes be Improved?

At the outset of this research I set out to investigate how the conflicting ideologies driving health reform in the period of study, 1983 – 1997, have served Mäori interests, in particular their expectations of partnership under the Treaty of Waitangi. The research has attempted to investigate the proposition that the Crown's attempts to address Mäori health needs in a largely unilateral way, rather than using frameworks for partnership consistent with the Treaty of Waitangi, have not met Mäori aspirations in respect of participation in health sector decision making nor significantly affected the problem of Mäori health needs during the period of study.

In this concluding chapter I argue that my research suggests the Crown is aware of its responsibilities in respect of Mäori health, has had little difficulty in generating quantities of Mäori health policy, and is aware of its own failure to translate those policies into effective response to Mäori. The preceding chapters demonstrate unilateral processes of reform, from either side of the political spectrum, have commonly failed to engage Mäori in the sort of partnership that they expect under the Treaty of Waitangi. Leadership within the health sector that ensures Mäori of a partnership with the Crown at all levels of the sector has not been forthcoming in the period of this study.

As is evident from the preceding chapters, the New Zealand health sector has not had a lot of stability over the past fourteen years that this study focused on. With further structural change embarked on by the 1999 Labour/Alliance Government, there are risks that gains in Mäori health service delivery will be lost, that Mäori participation in the health sector will be compromised, and that Mäori health status will further deteriorate by comparison with their fellow citizens. The key areas of risk are identified within this section. Effective management of these risks will contribute to improving Mäori health outcomes.

I conclude the chapter in two parts: suggestions for the Crown as to the means whereby it can engage Mäori effectively in the challenge to improve Mäori health, and a final concluding comment on the lack of inclusion of Mäori in health reform processes to date, effectively constituting an ongoing breach by the Crown of the Treaty of Waitangi, in respect of Mäori health.

## Failure of leadership

### Mäori Health - An Overview

The Wai 692 claim to the Waitangi Tribunal discussed earlier (Chapter 6) subjected the Crown's record in health services to an unprecedented level of scrutiny. The Crown defended the claim by presenting a total of nine witnesses. These were predominantly senior officials of the Ministry of Health, Health Funding Authority, CCMAU, and Healthcare Hawke's Bay.

Those witnesses painted a grim picture of Mäori health, and the inadequacy of the government's attempts to improve it. Ria Earp, Deputy Director General of Health

(Mäori) was cross-examined in some depth in respect of the Ministry of Health document "Action for Health and Independence - Bridging the Gap between Actions and Outcomes... the population perspective - Mäori Health Issues." (Ministry of Health, 1998). She described the document as "certainly supposed to represent or give a generic overview" (Ria Earp evidence for the Crown concerning Napier Hospital Services Claim, Waitangi Tribunal July 30 1999, transcript p122 lines 6-27) of the state of Mäori health at its publication. The document had the following to say about the state of Mäori health 15 years after the commencement of the structural reforms:

> Background on Key Issues for Mäori Health
>
> There has been a steady improvement in infant mortality and life expectancy, for Mäori, over the last four decades. The ill health status for Mäori, in a number of areas, has also improved over time, for example, reduced death rates for sudden infant death syndrome (SIDS) and higher immunisation rates.
>
> Despite these improvements, however, the gap between Mäori and non Mäori has still widened across the whole spectrum of ill health, including SIDS, immunisation rates, glue ear, asthma, youth and teenage pregnancy, youth suicide, self injury and motor vehicle injuries, cancer, diabetes, stroke, pneumonia and influenza, and mental ill health (Ministry of Health, 1998, p5).

Clearly, in spite of years of well-intentioned policy, the gap between Mäori health and that of other citizens (Article III rights) continued to widen during the period of the study.

## Mäori Health strategies during the reforms

My research is clear that the Crown clearly knew that Mäori health status was not at acceptable levels for much if not all of the period under study. The Labour Government's 1989 national health charter (1989, p5) had identified Mäori health

as a priority. The National government that followed had also identified as the Crown's objective to meet special Mäori needs that:

> The Crown will seek to improve Mäori health status so that in the future Mäori will have the same opportunity to enjoy at least the same level of health as non-Mäori (Department of Health, Whaia te ora mo te iwi - Strive for the good health of the people, 1992, p13)

When challenged by counsel for the claimants at the Wai 692 hearing, Ms Earp identified the objective as a medium term one, requiring three to five years to achieve. Furthermore, she agreed that the time elapsed since the objective was promulgated effectively amounted to nearly two medium terms, and that the objective had not as yet been realised.

> **MR POWELL (Counsel for the Claimants, Wai 692):** What you're really saying is, since Whaia te Ora came out, we've had two medium terms, or perhaps a medium and a half if you take it as five years, and we haven't achieved our medium goals in that time?
>
> **MS EARP (Deputy Director General, Mäori Health, MOH):** No, and I think anyone who would get up on the stand, and perhaps talk about the issue of health outcomes, would say that it is a long-term issue, achieving those kinds of improvements. They are not improvements that are necessarily achieved overnight; there may well be, in some specific areas, things that could be done - that can be - where improvements can be made more quicker than others (Ria Earp, evidence for the Crown concerning Napier Hospital Services Claim, Waitangi Tribunal July 30 1999, transcript p140 Lines1-37)

CCMAU , another Crown agency representing the ownership interests, was quite clear on the strategies that it had at its command to influence HHSs. However, it had not until very recently (CCMAU, 1999) seen that it had any responsibility to do so in respect of Government Mäori health policy.

The Minister of Health, one of the two "owners" represented by CCMAU stated the following medium term policy goal in a recent publication:

> Make marked progress in decreasing the long-standing disparities in health and disability status, in particular for the needs of Mäori and for the needs of pacific peoples so those groups can enjoy the same level of health as other New Zealanders (Minister of Health, The Government's Medium Term Strategy for Health and Disability Services 1999, p3)

The six years between the two policy objectives have clearly made little difference to the state of Mäori health disparity. There is little evidence of a new approach on the part of the Ministry of Health, and the Deputy Director General could only state she remained "hopeful" of some improvement in the medium term, while conceding that the issue was really a long term one (Ria Earp, evidence for the Crown concerning Napier Hospital Services Claim, Waitangi Tribunal July 30 1999, transcript p141 L29-36, p140 L22-39)

## Sector Responsiveness to Mäori

Ria Earp's "generic overview " (Ministry of Health, 1998) document, as she referred to it in the Wai 692 hearings noted the need to focus on "Improving mainstream responsiveness to Mäori" (Ministry of Health, 1998) as a key strategy for closing health disparities between Mäori and non-Mäori. Indeed, such a strategy was critical to the improvement of Mäori health disparity, as the Article II Kaupapa Mäori strategy could not deliver on its own.

> The health sector needs to ensure mainstream providers take responsibility for Mäori health. To do this successfully, they must work in partnership with Mäori to reduce barriers and improve the access Mäori have to health services. Innovative Mäori health services have been successful in responding to Mäori health needs. However they are too few and too small to turn around the poor Mäori health status by themselves....Mainstream health services would benefit from developing better relationships with Mäori providers, and this would contribute to Mäori health gain by assisting them and identifying and filling the gaps in health services to Mäori (Ministry of Health, 1998)

Clearly, the Ministry is acknowledging that:

- Mainstream providers, including Crown-owned entities, have failed to take responsibility for Mäori health.
- That the development of Mäori health providers in isolation cannot and will not solve Mäori health disparity

Ms Earp accepted that unless mainstream providers took responsibility for Mäori health and began working on a full partnership they could not effectively deliver health to Mäori (Ria Earp evidence for the Crown concerning Napier Hospital Services Claim, Waitangi Tribunal July 30 1999, transcript p124 lines 1-13) The fact that the Ministry of Health was identifying a need to improve the mainstream responsiveness to Mäori after fifteen years of health reforms is somewhat overdue recognition that there is a major problem with such responsiveness.

## Sector Identification of Continuing Mäori Health Problems

The five Ministry of Health Mäori health briefing hui which were the focus of the "Bridging the Gap" (Ministry of Health, 1998) document were held around New Zealand (Palmerston North, Rotorua, Invercargill, Christchurch, and Auckland) in August 1998. Ria Earp identified these hui as being important, successful, and involving a wide cross section of participants from the Mäori health sector (Ria Earp evidence for the Crown concerning Napier Hospital Services Claim, Waitangi Tribunal July 30 1999, transcript p121 lines 34-49, p 122 lines 1-4). She accepted that the hui identified a large number of significant problems in relation to health service design and delivery and Mäori health. These included:

- Data collection problems, including the lack of systematic collection of ethnicity data, and the range and quality of other data such as income levels
- The lack of robust or any monitoring and accountability mechanisms , between the Crown and its various agencies involved in health, most notably the funder, and between the agencies themselves.

- The lack of universal internal monitoring capabilities amongst providers.
- A lack of safe practice and responsiveness in respect of Mäori culture and values.
- A need for increased responsiveness of the funder and service providers to the needs, rights and interests of Mäori.
- The need to specify services to and outcomes for Mäori (Ministry of Health, 1998 p14-18, & Ria Earp, evidence for the Crown concerning Napier Hospital Services Claim, Waitangi Tribunal July 30 1999, transcript p 131-136)

The range and depth of the problems identified indicate the level of abject failure on the part of the current health system as it has half heartedly endeavoured to respond to Mäori health needs. Ria Earp stated as much when she admitted that the issue of accountability alone was sufficient to require a wholesale improvement of the health sector.

> **MR POWELL:** But what I'm saying to you is that, that particular concern for improvement, I think it is, that they're looking for improved accountability, goes right across the whole Health Sector, isn't it? It's not just limited to one part of it, it's improved accountability right across, between all indeed facets?
>
> **MS EARP:** It is saying that the whole Health Sector needs to be improved; that is what it's saying (Ria Earp, evidence for the Crown concerning Napier Hospital Services Claim, Waitangi Tribunal July 30 1999, transcript p135)

More recent health policy statements reiterate the commitment of government "to reduce the health inequalities that exist between Mäori and other New Zealanders." (King, 2001, p6). The remainder of this chapter demonstrates how little the government has known about whether its reform strategies of the 1990s are making any difference in respect of these inequalities.

## Monitoring the Treaty and Mäori Health

This dissertation argues that the Crown and its agencies have failed to effectively monitor both Treaty compliance and Mäori health status. The Ministry of Health appears to have never conducted a national assessment of Mäori health. Funders have struggled to get their contracted providers to deliver adequate ethnicity data, a fundamental requirement of any attempt to monitor Mäori health gain. The Crown as owner of health sector or its agent, CCMAU, has not monitored Crown Companies. When the question was put to Crown Law to raise with CCMAU on the researcher's behalf, the Assistant Crown Counsel wrote:

> I am advised that no information is held by the Crown Company Monitoring Advisory Unit that specifically addresses your request for information on "how Crown companies are monitored to ensure the principles of the Treaty of Waitangi are upheld and the interests of the Mäori Treaty partner are protected." (Linkhorn, Letter, 1999)

CCMAU developed performance measures to monitor the effectiveness of Crown Health Enterprises, provide information on service delivery and assist HHSs in becoming successful health providers. However, in these performance measurements there was no reference to Mäori and what was a quality service for them. There appears to have been no measurement of effectiveness of the health services provided to Mäori or how the HHS established whether it would meet the Government's identified targets for Mäori health. The government continues to state that Mäori health is one of its health gain priority areas.

It is evident that the opportunity to measure the perceived Mäori health gain through HHS quality reporting measures was not done by either CCMAU or HHSs themselves. If neither of those organisations attempted to measure improvement in Mäori health, will the government actually require any of its agencies to do so? If the Crown does not know whether it is making progress in this priority area, calling it a priority becomes little more than rhetoric.

### Article II and III

It is clear from interviews for this research that there is a poor understanding amongst health services of the health sector responsibilities of the Crown under Article III. The implications of Article III for the Crown are described as "the health status of Mäori should be improved to equal that of non-Mäori" (Policy Guidelines for Regional Health Authorities, 1995/1996). Although successive governments during the period under study have accepted that Mäori health should be a priority area, it is evident from the interview data that entities in the health sector did not understand how to respond to that priority. Providers do not understand how to operationalise the policy priority, or even that there is an onus on the Crown to reduce disparity and achieve equality of health status for Mäori (Interview with Canterbury Health Senior Staff, 2000). What is evident is that the health status of Mäori continues to deteriorate.

There has been significant regional variation in HHS models for improving their responsiveness to Mäori. There was no consistency of approach among the HHSs as to how to ensure participation of Mäori in all levels of decision-making, representation of Mäori in the organisation, development and implementation of policy that recognises Crown Treaty responsibilities to Mäori. There has been no

leadership from any central agency, be it Ministry of Health, CCMAU, or the Health Funding Authority to try to develop such consistency.

The poor understanding by the health sector of Article III and consequent lack of implementation within the sector has been compounded in this researcher's view by lack of leadership from the Ministry of Health. The Ministry of Health is charged with the responsibility of providing the Minister of Health with advice and development of policy. Many providers interviewed in the course of this study believe that policy is developed in isolation from the sector without a clear understanding as to the impact policy will have at the local level. Furthermore, the policy that is developed appears to be poorly communicated, inadequately explained, and is not given either a strategic or a political context.

## Political Response

The three-year political cycle compounds the problems in delivering effective outcomes from Mäori health policy. The politicians tend to focus on structures and structural solutions. It appears they assume nothing positive comes from previous administrations. It is clear from the policy review of health sector policy development on Mäori health within the study period (in Table 6) that there is a repetitive cycle reiterating the proposed policy initiatives to address Mäori health status. The same issues are repeatedly raised in this cycle - reviews of the Ministry, recruitment, policy templates, fatigue for Mäori as positions are recycled, tied to the lifecycle of an individual politician, prevailing ideology or term of government.

It is perhaps inevitable that any politician wants visible, immediate results. However, the political will required to address Mäori health disparity must engage with the fact that the required remedies are not short term. Those remedies cut across professional and political interest groups, and in an environment of health rationing, advantaging Mäori service delivery to remedy poor Mäori health status is not a politically popular action. It is little wonder then that health service providers find difficulty delivering on the government priority in this area. They need look no further back than the fate of the Public Health Commission in 1995 under the National government of the time, to see the consequences of voicing health messages that are not politically or economically popular.

## Further Reform and its Risks

### Transition / Fragmentation

Ongoing restructuring of the health sector brings with it the loss of structural understanding, and the loss of established sector relationships. Existing accountability within the sector has been fragmented as a result of the 1990s reforms as illustrated in earlier chapters. While the establishment of District Health Boards in 2001 may lead to enhanced local accountability, there is a significant risk that that accountability will be interest group rather than need driven. If the experience of the 1990 reforms is anything to go by, good intentions at the political level may not translate to action in the community:

> **MR CLARKE (Member of the Waitangi Tribunal Hearing Wai 692):** Mr Flowers, the Omahu hui has come up with just about every one of the last three speakers - one of the last four speakers in fact. So, obviously, it is one of the integral issues of this whole matter; the whole question of consultation in regard to the setting up of the Health Centre in Hastings. I

just couldn't catch your answer, or the answer of the Chairman of the board; were you in attendance at that hui?

**MR FLOWERS (Chief Executive Officer, Healthcare Hawke's Bay):** Yes, yes, I was.

**MR CLARKE:** What about the Chairman?

**MR FLOWERS:** No, he - no, he wasn't there, no. I think he was represented by Mr Moore, one of the Directors.

**MR CLARKE:** So, that particular hui was specifically held for Mäori throughout the Hawke's Bay District, and we referred here, extending from Mahia to Central Hawke's Bay, more specifically Porangahau; that was the area that was outlined by Mr Puriri. And, you - your organisation had decided that that was the best way of obtaining a Mäori point of view. Would that be right? Was to have that hui?

**MR FLOWERS:** At that level, yes. It was coming in in addition to the series of three or four stakeholder meetings, which had Mäori people on them as well; and that was the perception at the time, that that was the best way, yes.

**MR CLARKE:** But, of course, it was involving many different communities in that area, as I said, extending from Mahia out into - to Wairoa, into this area, and into the Central Hawke's Bay area, particularly Porangahau. So, there was a number of communities, different communities, asked to assemble; and it was the best way, as far as you were concerned, of obtaining a Mäori point of view.

This article here, Whaia te Ora Mo te Iwi, Strive for the Good Health of the People, was discussed in conjunction with Mr Keelan's evidence. It's the Mäori Health Policy objectives of Regional Health Authorities and the Public Health Commission. It's an interesting document. It was published in 1993; 1993, before the Omahu hui.

There's a paragraph here that talks about the way in which the policy was to be discussed with Mäori, and this is coming from central Government; from the top. And it says, "Ministers took the statement to marae", not Middle Managers, not Advisory Groups; the top dogs. And in your case the top dog would have been the Chairman of the board, and here we're saying "Ministers took the document to maraes", okay. And this article also says "Ministers took the statement to marae around the country". They just didn't have one hui in Wellington for all Mäori, all right. So, I guess there's a parallel between your situation and the situation relating to what the Minister did in 1993.

The document also says, "the matter was taken around, in what I took, to present the Government's response". And, like you, they thought that the method that you used, of face-to-face on the marae, was the best option.

They used the expression "and to present Government's response, kanohi ki te kanohi", okay; kanohi ki te kanohi. And for them that means - it's a translation of "face-to-face", it's exactly the same.

So, obviously you could say that, this comes from the centre, from the Ministers involved in Health. Kanohi ki te kanohi seems to be a policy for Ministers of Health as early as 1993, when consulting with Mäori communities, going to each of these communities and talking to them kanohi ki te kanohi, okay. Would you like to comment on that?

**MR FLOWERS:** Well, the only comment I can make to that is that, I think with a perception and the sense that I personally would have now, I wouldn't have any argument with, I think, the position that you are making. The difficulty was that it didn't, rightly or wrongly, it did not appear like that at the time as being the best method to use.

There were, as you know, stakeholder groups set up by Healthcare Hawke's Bay as the best way of trying to work through what is, I'm sure everyone would agree, was a very complex process, and that included several Mäori people. And the expectation was that that would ensure - and of course there were many interested parties as well as other interested parties - that would ensure that a good dialogue went on within the community, and that those views and concerns and ideas were fed back into the next stakeholder meeting process. That was what was set up which, presumably, at the time was regarded as the best way of doing it.

The Omahu Marae consultation, as I understood it at the time, was coming at the end of that sort of process, which was intended to draw out all of the issues, and try and get those out into the open for a final sign-off - if you'll pardon the expression - for that; some sort of completion of that process. And, that was the intent.

**MR CLARKE:** It's also interesting to note, Mr Flowers, that Mara Andrews talked about the numerous hui that was held by the Central Regional Health Authority around the same period; and there were many hui held in this area, okay. So, you've got the Ministers of the Crown, Central Government, doing this kanohi ki te kanohi in detail, and you've also got the Central Regional Health Authority doing the same thing, and then you've got Hawke's Bay, your group, giving its best shot; one hui. You see, all these other groups are doing it, all your masters, you could say, they're doing it. But you decide this was your best shot; one hui, Omahu, and all these different communities.

**MR FLOWERS:** Well, I'm not aware of the HFA undertaking a number of hui at the same time. I thought that series of hui commenced afterwards, but maybe I'm incorrect in that, but that was my recollection of it. It was a decision made jointly with the Health Funding Authority at the time. Their advice came into that decision as part of the process.

**MR CLARKE:** That's all I wanted.

**MR FLOWERS:** If I may just add one more point. The clear perception at the time, and I think it would still be the case, was that the main obligation for consultation, on the matter of Health Services in Hawke's Bay, lay with the Health Funding Authorities in both statutory terms and in terms of what they're trying to set out to do. There was no obligation at all on Healthcare Hawke's Bay to undertake consultation. We chose to for all the reasons that you're describing, that it's important to have a community view on some critical decisions.

**MR CLARKE:** But someone, a member of your team, it may have been your Chairman, talked about the importance of the principles of the Treaty of Waitangi.

**MR FLOWERS:** That's correct, yes.

**MR CLARKE:** Yeah, so we need to take that into account. But, it's interesting to hear Mr Keelan talking about these policies that are going to be infused into your healthcare district, okay; the Mäori perspective is going to be infused right throughout this whole area. And it seems that the fundamental reason for that, it's probably a better way, a more effective way, culturally more sensitive, to do it this way, do it the Mäori way, okay; do it the Mäori way. And obviously the kanohi ki te kanohi is a Mäori way that maybe you didn't take advantage of?

**MR FLOWERS:** There are many parts of the process of this whole thing, in relation to Mäori and in relation to many other things that, when I'm doing it next time, will be different. And, I quite agree, there are - and I think - I would like to say that the way in which Wi Keelan is advancing that type of concept and philosophy, in the way we do things within Healthcare Hawke's Bay, is extremely productive; it's a very satisfactory way of proceeding with that, and I just wish he had been part of organisation at the time.

**MR CLARKE:** Thank you very much, Mr Flowers (Mark Flowers, evidence for the Crown concerning Napier Hospital Services Claim, Waitangi Tribunal August 2 1999, transcript, p445)

## Representation

There has been longstanding concern about the lack of Mäori representation at the senior levels of decision-making in the health sector. As far back as its 1986 memorandum 'Treaty of Waitangi and Mäori Health', the Department of Health

recognised the need for greater participation and representation of Mäori in the development and delivery of health services:

> "That Mäori health issues be addressed by the involvement of a greater number of Mäori people in the delivery of health services and the setting of priorities..... challenges health decision makers to involve Mäori people in the development of plans and priorities" (Steering Group, Ministers of Health, 1997, p54)

The active support for Mäori representation was less visible in the successive government health policies of the 1990s. The Health and Disability Services Act 1993 contained no requirements for representation by Mäori on Boards of the new health bodies. The Boards of CHEs were now appointed by the Minister of Crown Health Enterpirses. Where Boards had Mäori directors, they were not necessarily either local or mandated by Iwi to represent their views. The number of Mäori directors of HHS companies prior to the transition to the DHBs was fifteen out of a total number of 133 and of that fifteen only six were Mäori women.

Mäori are obviously concerned to ensure they have adequate representation on the Boards of the new DHBs. When nominations were invited for the transitional Boards in 2000 Mäori candidates comprised some 22% of all candidates. Naturally, many of those Mäori with health sector expertise work for or with Mäori health providers. There is a considerable risk of under-representation of Mäori in the new structures if an undue influence is placed on potential conflict of interest in selection of the new Board members. The same conflict of interest may not be challenged for non- Mäori where they are part of providers such as IPAs.

### Consultation

The 1999 Labour-Alliance government embarked on the latest round of health sector restructuring believing it had a mandate, if not from the sector, at least from the electorate. Consultation concerning the structure as mandated by the New Zealand Public Health and Disability Act 2000 was limited to the select committee process. It appears little has been learned about consultation with Mäori from criticisms to date of the health reform consultation processes during the period of this study.

## Successful Mäori Health Outcomes

### *The Treaty of Waitangi should be the Central Framework for Crown Mäori Health Policy*

One overall critical conclusion of this research is the lack of a consistent framework or "big picture" for the health sector to address health disparity for Mäori. The consequences are an inconsistent approach that does not impact sufficiently on improving the health status of Mäori. The obvious framework that is recognised as the basis of the constitutional government of New Zealand and would provide sector consistency is the Treaty of Waitangi. Health policy has recognised the Treaty and discusses the importance of the Treaty. This is not a formal Treaty framework. Policy has tended to be equity based not Treaty based and the emphasis has been on achieving equitable outcomes for everyone. Addressing disparities will address part of the Crown Treaty obligations but, I argue, does not recognise Mäori rights under the Treaty to preserve and protect their own health status.

Previous legislation for the health sector reflects this as it has never had a Treaty of Waitangi clause. Recognition of 'the special needs of Mäori and other particular communities or people for those services' as stated in the Health and Disability Services Act 1993 is not Treaty based. The combination of lack of specificity in the legislation and non-Treaty based policy reinforces the equity approach. The Treaty could give consistency and overarching clarity to the health policy framework.

*Continue to support "By Mäori for Mäori" Health Initiatives*

The Ministry of Health has convinced itself the health sector is being Treaty responsive and addressing health disparities due to the growth of Mäori providers (Earp, 2001). This highlights the poor understanding of the Treaty in the health sector. The growth of Mäori health service providers is significant as an Article Two response and strategy. The "By Mäori for Mäori" initiatives are important as a combined Article Two and Three strategy that has the potential for the maximum impact on improving Mäori health status. The Mäori health provider initiatives and their influence on such factors as smoking cessation and immunisation rates suggest that these services at least have higher levels of acceptability amongst Mäori service users.

The research indicates from the interviews conducted with health sector participants that the health sector has a poor understanding of the Article Three responsibilities on the Crown. The implications of Article 3 for the Crown are described as "the health status of Mäori should be improved to equal that of non-Mäori". It is evident from the research interviews that different entities in the health sector do not understand how to respond to that priority.

### *Establish Clear Guidelines in Implementing the Crown's Article III (Mainstream) Māori Health responsibilities*

I argue that the poor understanding by the health sector of Article III and consequent lack of implementation within the sector has been compounded by lack of leadership from the Ministry of Health. The role of the Ministry of Health should be to lead and influence the health and disability sector and to provide skilled policy advice about regulation, funding management and monitoring of the sector. During this research a consistent criticism voiced by many interviewees (see Chapter 7 - Crown Accountability to Māori - Monitoring of the Health Sector and its Impact on ) regardless of their geographical location or organisational type was that health policy is developed in isolation from the sector. Policy was also described as poorly communicated and developed without a clear understanding as to the impact it will have at the local level.

This was evident in the significant regional variation of HHS models (from 1996-99) in their attempts to improve their responsiveness to Māori or even in the recognition of the need to. There was no consistency of approach among the HHSs as to how to ensure participation of Māori in all levels of decision making or representation of Māori in the organisation, development and implementation of policy that recognises Crown Treaty responsibilities to Māori.

A national framework for the entire sector would allow a consistent approach to be taken. Prior to the development and implementation of a framework a national review of Māori health status also needs to be conducted. A baseline needs to be established so that there is a clear understanding as to what exactly needs improving and so that gains made can be measured. If Māori health gain is a

priority, then it makes good sense to begin a national review process with them. Such a review process should be transparent, separately funded, accountable to and enabling participation of Mäori, rather than an imposed technical assessment done to Mäori by 'experts' such as demographers and epidemiologists.

The opportunity of implementing such a framework in the 2000 DHB based reforms has not been taken. While there is a commitment on the part of the current government to have a minimum number of Mäori on each District Health Board, the means of developing a partnership relationship with mana whenua or local Iwi have been left to the discretion of the Boards themselves. Given that they are based on the previous HHS entities, the variation evident prior to 1999 is likely to continue.

### *Proposed Key Performance Parameters*

In order to measure Crown performance in respect of Mäori health, the following performance indicators are proposed.

**The Crown as the Primary Mäori Health Service Provider should:**

1. Incorporate the Treaty of Waitangi in the new Health sector legislation
2. Include clear statements of the Crown's view of its health sector responsibility under both Article II and Article III
3. Ensure equitable numbers of Mäori members are elected or appointed to District Health Boards
4. Ensure that sector leaders including DHB boards and Chief Executives are both competent in and evaluated on

ability to apply the Treaty in changing Mäori health

s.

5. Develop a work programme to consult Iwi about Mäori health

strategy and policy development with specific attention to:

- A national review of Mäori health status
- Iwi control of health data such as consumer level ethnicity information
- Iwi monitoring of Crown performance in Mäori health
- The development of explicit Mäori health targets
- The development of the Mäori health workforce

6. Require all Crown health entities to explicitly identify their spending on Mäori health activities
8. Develop information and communication strategies to ensure mainstream providers and the New Zealand public understands and supports the Crown's intentions in respect of the Treaty and Mäori health.

**Other Mäori Health Services should:**

1. Demonstrate an increasing equity of outcome between Mäori and non-Mäori service users
2. Ensure participation of Mäori in significant decisions effecting the delivery of services
3. Demonstrate increased acceptability of health services by Mäori service users
4. Demonstrate service contribution to Mäori health capacity building
5. Contribute to increased knowledge of effective Mäori health interventions and strategies

## The Breach Goes On

This research shows there has been no shortage of good intentions documented by the Crown and its agencies in respect of Mäori health over the recent reform period within this study. Mäori health policy exists in abundance. However, such policy is not rooted in a consistent framework. Accordingly, it is reconstituted in a regular cycle, and has provided little guidance to a health sector undergoing almost continuous change itself in recent years. Consistent policy and action are needed for impactful change.

Crown entities and political parties over the last seventeen years have acted as though they have a right to embark on health sector change in a unilateral fashion. They cannot leave the system alone. They are constantly tinkering with the structure, and there is a lack of consistent vision and theoretical rigour to their approach.

I argue that the Crown has been unable to create structures or processes through its health reforms that deliver effectively for Mäori health. Crown agency understanding of the Treaty and their obligations has been minimal:

> **PROF SORRENSON (Member of the Waitangi Tribunal Hearing Wai 692):** Yes, I think I want to bring up the issues of consultation, the same sort of thing that Mr Clarke's been talking about, but from a slightly different perspective. You made a statement just a minute ago that I found rather surprising and I think, if I heard you correctly, you said there was "no obligation on Healthcare Hawke's Bay to undertake consultation". Do you mean by that, there's no obligation under the Treaty to undertake consultation?
>
> **MR FLOWERS (Chief Executive Officer, Healthcare Hawke's Bay):** Sorry, no, I didn't mean that. What I meant was, there is no legal obligation, as I understand it, for Crown Health Enterprises, as they then were, to consult with the community.
>
> **PROF SORRENSON:** There was no obligation to consult?
>
> **MR FLOWERS:** That's my view on the position, yes.
>
> **PROF SORRENSON:** What's your understanding of Healthcare Hawke's Bay's obligations, as a Crown Enterprise, under the Treaty?
>
> **MR FLOWERS:** In respect to consultation?
>
> **PROF SORRENSON:** Well, that's just one aspect of it; but generally speaking, what's your understanding of its obligations to the principles of the Treaty?
>
> **MR FLOWERS:** I have the sense of being faced with an enormous question. I mean, as I perceived it, and it's certainly to take proper account of the relationship between the Crown and Mäori in significant decisions; to ensure that the interests of Mäori are protected and considered as part of the decisions, and to promulgate things that are of importance to Mäori in

the way we go about our business and provide our services; to protect certain rights, such as privacy rights and the like. Those are the ones that immediately come to mind.

**PROF SORRENSON:** Yes. Have you any, or much knowledge of discussions about the principles of the Treaty? For instance, the - I suppose one should say innumerable discussions in Tribunal reports in court judgments, like the Lands case in the Court of Appeal in 1987?

**MR FLOWERS:** A very limited exposure to that.

**PROF SORRENSON:** I mean, as a CEO, you don't - of a Crown Enterprise, you don't really consider it your, sort of, obligation to become Treaty literate?

**MR FLOWERS:** I certainly do, yes. I'm sorry, maybe I misunderstood your question. I read and I discuss these issues many times, and I haven't had any specific questions about Tribunal judgments.

**PROF SORRENSON:** You read and discuss them, but do you sort of bring them into your decisions, or the decisions that --

**MR FLOWERS:** Yes, I attempt to do that, and I most recently have tried to ensure that the board itself develops a clear policy, a company policy, around the matter of Treaty obligations and I've ensured in recent years, since I became CEO, that there are proper statements about some of these principles in the annual business plan and the like.

**MR FLOWERS:** Yes.

**PROF SORRENSON:** How do you think partnerships should operate, particularly in terms of consultation between the two Treaty partners?

**MR FLOWERS:** Well, to me, it must operate as a number of different levels. There should be, and starting for no particular reason, at the level of the governance of the organisation; there should be clear partnership principles stated in terms of the company policy and the role and obligations of the Directors, and that's what we have been most recently dealing with.

At the level of management, there should be a clear and proper representation of a Mäori perspective, and advice and views at the management level, and that's what Mr Keelan provides and why his position now reports directly to me; and then, at the level of providing Health Services. And, to do that effectively, particularly in some areas of health, it's vitally important that there not only be Mäori staff as part of the health provisional team, but also that in some cases it may be better for us to provide services jointly with other Mäori Health providers, or indeed to contract to them, or indeed for us not to attempt to provide those services at all. So, I see it as a multilevel obligation.

**PROF SORRENSON:** Yes. Would you agree that the two partners should consult, and that Mäori views should be taken into account before a decision is made?

**MR FLOWERS:** Yes, I do, absolutely.

**PROF SORRENSON:** You see, my feeling of this whole process that's gone on here, particularly - I mean, particularly in relation to the decision to concentrate the hospital facilities at Hastings, is that - and I'm not accusing you personally of this, because you didn't become Chief Executive until 1996, after the decisions were made, but an essential predecessor seems to have decided that, for all sorts of good technical reasons, clinical reasons, administrative reasons and so on, this was a necessary decision. Yet, the decision itself might have been carried out in such a way that you were breaching the principles of the Treaty by not, effectively, consulting with your Treaty partner. That's what I mean.

**MR FLOWERS:** Yes, I understand that.

**PROF SORRENSON:** Yes; would you agree that that could have happened?

**MR FLOWERS:** Yes.

**PROF SORRENSON:** You do. Thank you very much (Tribunal questioning of Crown Witness Mark Flowers, evidence for the Crown concerning Napier Hospital Services Claim, Waitangi Tribunal August 2 1999, transcript p448)

In my view the health reform process from 1983 to 1997 has clearly not had nearly the level of inclusion that Mäori have a right to expect as a result of the Treaty. Partnership has been evident in the exception rather than the rule. My position is that the fact that the Crown has inadequate monitoring and control mechanisms in the health sector to ensure Mäori are appropriately included, is, in itself, a breach of compliance with the Treaty. In my view, the recent process of reform, with the implicit assumption by parties in government that the democratic process gives them the only mandate they require to change the health system, is in itself a breach of the Treaty requirements for partnership, consultation, representation, and participation.

# POSTSCRIPT - AFTER 1997: THE FUTURE AND ITS ANTECEDENTS

There is a strong sense of déjà vu in developments in the New Zealand health sector in the post 1997 political scene. There is a sense of having been here before, of the newly created District Health Boards of 2000 resembling the old Area Health Boards of the late 1980s. There is a strong sense that the place of the Treaty in health is being litigated yet again, and that the place of Mäori interests is secondary to the political imperatives for change.

## The 1996 National-New Zealand First Coalition Government: Health Agreement: A Softer Gentler Health Service?

The Coalition agreement between the National Party and the New Zealand First Party was entered in order to enable them to form a government with a majority after the 1996 election. The Agreement covered a wide range of policy related to the state sector. The influence of Ka Awatea (1990) is evident in the health policies and the way in which health disparities were to be addressed.

The major structural change to flow from the coalition government efforts was that the four Regional Health Authorities created in 1993 were combined into the Transitional Health Authority, which was subsequently replaced by the Health Funding Authority, formally created October 1 1998.

The 1998 change in name of the state health providers from Crown Health Enterprises to Hospital and Health Services derived directly from the National-New Zealand First Coalition agreement. The politicians argued that it was more than a name change. The key initiatives of the health policy focused on increased resourcing and structural changes such as the centralisation of the functions of the Regional Health Authorities. Crown Health Enterprises, soon to become HHSs, were required to have less of a commercial focus or profit motive, and were now to operate only in a "business like manner". Other changes included the return of a level of direct community representation, with local Councils being invited to nominate two candidates for inclusion on CHE Boards, with the condition that they not be sitting Councillors.

Mäori health remained a high priority for government in its funding and delivery of health services under the National-New Zealand First Coalition agreement. Policy advice to the incoming National-New Zealand First Coalition government following the 1996 election stressed that the three key issues in Mäori health were:

- Mäori health remaining a health sector priority for improvement
- The need to consolidate gains in Mäori health development
- The need to continue to acknowledge the special relationship between Mäori and the Crown under the Treaty of Waitangi

Improvements in Mäori health status were identified as priorities.

> In recognition of Government's commitment to improving the status of Mäori health, increased resources will be made available to provide Mäori leadership within the health sector, and to enable the continuing growth and development of Mäori health service provision by Mäori (The National – New Zealand First Coalition Agreement on Health, 1996, p34)

The key initiatives of National-New Zealand First Coalition Mäori policy relevant to health included:

- Implement Ka Awatea as amended
- The development of the four Mäori Commissions, including the Mäori Health Commission, Mäori Economic Unit, Mäori Education and Mäori Employment and Training Unit
- To review the representation (of Mäori) on various government bodies (The National – New Zealand First Coalition Agreement on Health, 1996, p35)

The Commissions were expected to act as a "think-tank" to monitor progress and design initiatives to work with Crown agencies. They were established in 1997 and were accountable to the Minister of Mäori Affairs, Tau Henare.

However, while the National-New Zealand First Coalition Agreement health policy encouraged the development of Mäori health service providers, the Article Two argument of "by Mäori for Mäori" appears to have been supported as it coincided with the government's thrust towards decreased dependency on the state and the encouragement of the development of private providers to compete in the market, in preference to sole or primary state owned health service providers (Steering Group, Ministers of Health, 1997)

## The 1999 Labour Government: - Back to the Future

Prior to the general election of 1999 the Labour Party signalled their intention that the health sector would again be restructured should they become the government. Two of the strongest and most consistent criticisms Labour had voiced about the 1990s reforms were the dominance of a commercial focus and the lack of

openness and accountability. The Labour health policy stated that profit should not be the motivation of the public health sector; 'Labour will introduce the New Zealand Public Health Services Bill to ensure that hospitals are no longer under the Companies and Commerce Act and that cooperation rather than competition drives the health system'.

## Labour Mäori Health policy 1999

The Labour/Alliance Coalition Government was elected in 1999. The health policy and strategy that the Labour Party campaigned on revisited some of the policy they had promoted in their previous term of government (1984-90). Economic, social and cultural factors were described as the most important determinants of good health by this government (Turia, Lecture, 7 July 2000)

The Labour Mäori health policy stated that a Labour government would:

- Encourage the integration of culturally appropriate health services as part of the wider holistic approach to whanau, hapu, iwi and Mäori development;
- Ensure equitable representation on District Health Boards and cultural safety is part of on-going quality and safety monitoring across the health sector.
- Ensure the delivery of New Zealand Mental Health Strategy is consistent with Treaty principles, and that Mäori have access to mental health services that are aligned to cultural expectations;
- Identify and develop specialist services for tamariki, rangatahi, kuia and koroheke and increase the availability of kaupapa Mäori services to all Mäori across the health sector;
- Increase the Mäori health workforce, their skill base and encourage further professional development (Labour Party, 1999, Part 1)

The policy outline provided little or no detail as to how these gains would be achieved. There was no timeframe given as to when these commitments would be delivered on.

In 2000, at the commencement of their term of government Labour indicated that it was prepared to commence another era of significant health sector reform with scant detail provided. This raised questions as to how developed the policy was let alone its potential implications on the sector if Labour achieved a successful election to government.

There was no explicit Treaty of Waitangi reference to Crown and Mäori relationships in Labour's Mäori health policy (Labour Party, 1999, Part 1). When the Government was undertaking another round of extensive health reforms without a clear position on its Treaty relationship with Mäori and implications for the health sector there was cause for concern. A definite position on this would have underpinned structural reform and provided clarity as to the way they intended to move forward.

The policy did not make reference to complex issues of consultation with Mäori prior to the pending sector changes and the need for Iwi mandate for implementation at the regional level. Equitable representation on District Health Boards does not adequately address the Treaty responsibilities on the Crown and the special relationship between the Crown and Mäori, as it only addresses citizenship rights inherent in Article 3 of the Treaty. Rights of participation and partnership inherent in the other articles are ignored.

Labour Mäori Health Policy was consistent with that of preceding governments in their recognition of Article Two rights of governance of Mäori entities, and a lack of explicitness on Article Three accountabilities on the Crown. The addressing of inequities occurs in the general health policy;

> - Labour will rebuild a comprehensive public health system for all New Zealanders.
> - Labour will ensure that access to the health system is not limited by ability to pay.
> - ensuring strong community services and affordable primary care are accessible for all;
> - improving the overall health status of New Zealanders.
>
> (Labour Party, 1999, Part 1)

This did not explicitly address Article Three responsibilities, particularly the responsibility for ensuring Mäori citizens have health status no worse than that of their fellow citizens. The challenge of poor Mäori health status is ignored, with a focus on equity of access unlikely to redress past inequities, and thereby create equity of outcome.

### Labour-Alliance Coalition Government - District Health Boards and the Current Structure of the Health Sector

The 1999 Labour-Alliance Government further restructured the health sector, disestablished the Health Funding Authority and transferred its purchasing functions to 22 new District Health Boards. The rationale for this was to 'simplify health bureaucracies and cut administration costs' (Labour Party, 1999, Part 1).

The previous HHSs would expand to form the bases for 22 District Health Boards and have both the funding and service provider roles. The proposed structure had many similarities to the Area Health Board model of the 1980s though with eight more administrative regions than the fourteen AHBs of that time. The new structure provided for a return to local representation and accountability on the Boards and a community oriented public health service. The Government had committed to:

- establish District Health Boards, which will consult local people on five-year regional strategic health plans for the provision of local health services.
- return to elected representation and public accountability. District Health Boards will be made up of a majority of elected representatives
- empower local people to make decisions about their health services.

Thus the health sector since the 1999 election has again been in a time of structural transition and uncertainty. The new structure was to be in place by November 2000. This was the most rapid health reform process embarked on by a government in the last two decades. There was a stark contrast between the 1999 Labour-Alliance government time frame of a matter of months to the sedate and considered five-year pilot study of the Area Health Board model trialed in Wellington and Northland in the mid to late 1980s. The National government of 1990 allowed a two-year time of transition for the radical reforms of the health sector they introduced. Due to the speed that the 1999 Labour-Alliance government attempted to introduce change it was not surprising that the proposed timetable they were working to experienced some delays.

## The New Zealand Public Health and Disability Act 2000

The legislation that defined the new structure, the lines of accountability and the roles and responsibility was the New Zealand Public Health and Disability Act 2000. The Act replaced the Health Funding Authority and the HHSs with District Health Boards (DHBs). In the new structure the DHBs were to have a population health focus with the overall objective of improving the health of the population in their districts. DHBs were to be responsible for analysing the health and disability needs of their populations, and then either funding services from non-government providers to meet the identified needs, or providing hospital-based services from their own facilities. Boards would be made up from seven members elected by the DHB population, and up to four members appointed by the Minister of Health. Each DHB was to have a minimum of two Mäori members.

The Act included several sections aimed at achieving Government's objectives for Mäori health. The broad thrust of the specific Mäori sections was to:

- recognise and respect the principles of the Treaty of Waitangi
- establish mechanisms for Mäori participation throughout the sector
- protect gains already made and move forward to strengthen Mäori provider and workforce development, to improve mainstream service responsiveness to Mäori, and to close gaps between the health of Mäori and other populations (Mäori Health Directorate, Ministry of Health, Information Sheet - Provisions for Mäori Health and the Treaty of Waitangi in the New Zealand Public Health and Disability Act 2000 19 September 2000 update)

The Ministry of Health identified the key Mäori measures in the Act, as set out in Table 10 below.

# Table 10: Key Measures Specific to Mäori in the New Zealand Public Health and Disability Act 2000.

- A reference to reducing the well established inequalities which exists between different population groups within New Zealand society

  **Section 3(1)(b)** "to reduce health disparities by improving the health outcomes of Mäori and other population groups."

- A reference to the Treaty of Waitangi to give legal support and backing to the Government's commitment to the Treaty and Mäori health improvement:

  **Section 4:** "In order to recognise and respect the principles of the Treaty of Waitangi, and with a view to improving health outcomes for Mäori, Part 3 provides for mechanisms to enable Mäori to contribute to decision-making on, and to participate in the delivery of, health and disability services."

- DHBs will have the **statutory objective** of improving Mäori health outcomes and reducing disparities between Mäori and other New Zealanders. **Section 22: Objectives of DHBs**

- To ensure **effective Mäori participation and contribution to Mäori health improvement.**

  DHB governing boards will need to establish and maintain relationships with Mäori in their regions so Mäori can participate in, and contribute to, strategic planning for Mäori health gain. **Section 23(1)(d)**

- DHBs will have the statutory function of continuing **to develop Mäori capacity** to participate in the sector and to provide for their own needs. **Section 23(1)(e)**

- DHBs **must provide information to Mäori** for the purposes of Mäori partnership, participation, capacity building. **Section 23(1)(f)**

- To ensure an effective voice for Mäori at the DHB level:

  Mäori will be **represented on DHB boards**, with Mäori membership on boards proportional to the number of Mäori in the DHB's resident population, and a minimum of two Mäori on each Board (section 29(4)). DHB committees will also have Mäori representation. **Section 34-36 and Schedule 3(39)(2)**

  DHBs must also **consult with Mäori** in developing their district health plans. **Section 38(3)(a)**

- DHB boards must ensure board members are familiar with the obligations and duties of a member of the board, Mäori health issues or Treaty of Waitangi issues, and ensure any members who need to receive approved training Schedule 3 (5)(1) and 5(2)(c)

  *The whole board is accountable for the achievement of Mäori health improvement, not just Mäori members.*

- DHBs must be **good employers of Mäori** - which includes recognising the aims and aspirations of Mäori, the employment requirements of Mäori and the need for greater involvement of Mäori as employees. **Section 6:Interpretation**

- **DHB accountability arrangements and operating rules** will hold DHBs to account for achieving their Mäori health objectives and functions. This is achieved by linking DHB strategic district plans, district annual plan and reporting requirements under the Public Finance Act to their objectives and **functions sections 38(1)(a), 39(2)(b)(i), 42(3)(b).** Opening DHB meetings to the public **section 38(4),** making all DHB annual plans, agendas and reports available to the public (subject to some protections) **Schedule 3, sections 16 and 19,** and requiring disclosure of conflicts of interest for board members **Schedule 3 section 34** are other important accountability mechanisms.

  *These accountability mechanisms are designed to maximise transparency as well as effectiveness and efficiency - and among other things, to ensure DHBs use Mäori providers where that would be more effective and appropriate than using DHB services*

- Other mechanisms in the Act available to the Government to achieve its Mäori health objectives include **the New**

**Zealand Health and Disability strategies** (section 8), **Crown Funding Agreements** (section 10), the Minister's power to make directions (section 32), to **require provision of services** (section 33), or to **request information** from DHBs (section 44). The rewards and sanctions in the Act can also be used to get traction on Mäori health issues, for example appointing **a Crown monitor** to sit on boards (section 31), and the ability to **replace Boards** (section 31) **or dismiss board members** (Schedule 3 section 8). The exercising of these broader powers and functions will be subject to the Treaty provision.

- **DHBs boundaries** (as set out in Schedule1) are based on existing HHS boundaries and local authority boundaries. Traditionally this has meant iwi boundaries do not always align with HHS boundaries so just as has been needed in the past, ways will be needed to work around this.
- DHBs will be required to get the Minister's agreement or in some cases the agreement of the Attorney General to dispose of land under the Act (Part 7). The government policy is that DHB land will go through the **land-banking process**.

*The draft New Zealand Health Strategy and New Zealand Disability Strategy "Whakanui Oranga" contain high level goals and objectives for Mäori health. These will be further developed in the **Mäori Health Strategy**, which the Ministry is developing now.*

*The Ministry of Health will also develop guidelines/protocols, model agreements and disputes resolution procedures etc to assist the DHBs in achieving their responsibilities under the Treaty of Waitangi*

(Selective quotes from Mäori Health Directorate, Ministry of Health, Information Sheet - Provisions for Mäori Health and the Treaty of Waitangi in the New Zealand Public Health and Disability Act 2000 19 September 2000 update)

The Ministry identified a further work programme addressing policy and guideline development on the application of the Treaty of Waitangi and funding work to include the needs of Mäori communities. It also identified the timetable for the development of the Mäori Health Strategy, with a public discussion document (King, 2001) due by May 2001, and the final Strategy in August 2001.

Clearly, the stated intention as outlined in Table 10 is a more detailed attempt at bringing the Treaty back into focus within health sector structures. As such, it is reminiscent of the good intentions of the late 1980s Area Health Board period, it remains to be seen whether those intentions are any more effective at delivering for Mäori than they were the first time around.

## Restructuring Risks

While the new Labour-Alliance government of 1999 believed it had a mandate to return the health system to a more localised structure, not everyone agreed with this strategy. Te Puni Kökiri advised its Minister in January 2000 that:

> District Health Boards may interfere with the significant advancements over the past ten years in terms of Mäori representation in the purchasing and provision of health services (TPK, 21 January 2000)

Te Puni Kökiri had concerns regarding the direction of the restructuring, and what they saw as the very real threat to the Treaty partnerships established in health.

> Te Puni Kökiri is concerned at the level of genuine commitment the proposed structure has to improving health outcomes for Mäori. Considerable attention must be given to the obligations of the Crown in relation to the Treaty of Waitangi partnership requirements with Mäori. This partnership must be based upon equitable representation in both the decision-making processes and in the implementation of policy and services at both a national and local level. Te Puni Kökiri advises that implementation of the proposed health sector changes without adequate consultation with Mäori opens the Ministry of Health (as representatives of the Crown) to potential legal challenges on the basis of breaching Treaty obligations (TPK, 21 January 2000)

In the event, Te Puni Kökiri's concerns were to be justified. Mäori input into the New Zealand Public Health and Disability Bill was through the select committee process, on exactly the same basis as other citizens, rather than specific consultation with Mäori, in acknowledging their partnership role in respect of the Treaty of Waitangi.

Others, including Professor Mason Durie, the then chair of the National Health Committee, and an eminent Mäori Health academic, echoed their concerns:

> One of the characteristics of the (pre 1999) reforms was that there was some partial deregulation of the health sector and in that climate it was possible for providers of Mäori health services to begin to make a strong contribution. Now no-one's I don't think absolutely [sure] what the new look will be like in the reformed health service, but there is a concern that the balance between the national objectives that might be set and the local priorities could lead to some down-playing of Mäori health providers as a strategy for developing Mäori health. And that would be the concern...
>
> But what I'm not sure about is whether the District Health Boards will want to take a wider view than simply representation. Whether they will be concerned about how the Treaty of Waitangi might impact on their activities for example (Radio New Zealand "Checkpoint" 5-6 PM Friday 25 February 2000)

Mäori concerns were mounting. The response of Mäori to the call for interim District Health Board members was significant.

> "Treaty relationships already established in the health sector must be built on and improved by mana whenua and these Hospital and Health Services boards until the District Health Boards are established, and must exist at all levels of the decision-making process.
>
> "Participation in decision-making processes is therefore not optional for Mäori it is a requirement.
>
> "Whanau, hapu and iwi involvement in the new health structures through representation is an example of that requirement.
>
> "I am therefore very pleased at the response to the Governments' call for nomination for the extra places on the Hospital and Health Services boards.
>
> "There have been 408 Mäori people nominated, making up 22 per cent of the overall nominations. There is strong interest in every region and I thank you all for your willingness to become involved in the new health structures of this Government.
>
> "It is only through your willingness to participate and work with us, that the Government can fulfil its commitment to improve the Mäori health status and Mäori development (Turia, Press Release, 10 March 2000)

The Minister accepted that a level of concern was both evident and justified. She reassured Mäori that their health concerns remained a distinct priority for the government.

I accept that is a concern among Mäori and others in the community, that there could be backsliding in terms of Mäori provision and the building of Mäori capacity. I accept that is a concern and I'm also concerned to make sure that Mäori know that is not the direction of this government. We made it very clear in our policy that we want to develop services for Mäori by Mäori as a priority. That we want to close the gaps that we have in health status in New Zealand between Mäori and the rest of the population and we know that the best way to do that is actually to grow the capacity of Mäori to provide. So my task as I see it is to convince Mäori that they will not be left out in the health system reforms, that they wont be ignored by District health boards, and that in fact the growth of their provision is a priority for us (King, Radio New Zealand "Checkpoint" 5-6 PM Friday 25 February 2000)

## The Treaty in the Bill

The Minister set high expectations for Mäori in respect of the Public Health and

Disability legislation to enact the new health structure.

Reference to Treaty in Bill
The New Zealand Public Health and Disability Bill will include a Treaty of Waitangi clause to affirm and give coherence to the Government commitment to the partnership between Mäori and the Crown.

This will have a significant impact in reducing disparities in health between Mäori and other New Zealanders. Legislative provisions will empower DHBs to meet their objectives with regard to Mäori health. Mäori can have greater confidence that the health system will deliver more effectively for Mäori.

DHB boards will have an obligatory partnership to enable mana whenua to participate in and contribute to the development of strategic planning for Mäori health improvement in their regions.

There will also be other arrangements including memoranda of understanding or relationship agreements between the DHB and other Mäori organisations such as Mäori development organisations, to ensure Mäori generally have the opportunity to contribute to and participate in strategies to improve Mäori health.

DHBs will be required to continue to build capacity for Mäori to provide for their own health and disability needs and improve mainstream service responsiveness to Mäori.

Building on Achievements To Date
The Government is committed to protecting gains in Mäori provider development and to building on those gains.

It is envisaged that Mäori development organisations will evolve over time, taking on more responsibility as their capacity grows. Potentially they could evolve into organisations responsible for a wide range of services for Mäori, not just health.

Representation on DHB Boards
Mäori membership on DHB boards will reflect the proportion of Mäori in the DHB population, with at least two Mäori on each board. Ministerial appointments to boards will be used to supplement the results of the DHB elections to ensure this level of Mäori representation.

National Mäori Forum
A national Mäori forum will be convened at least once a year to provide Mäori representatives with an opportunity to discuss existing and future Mäori health policy directions with the Minister of Health (King, Issue 16, August 2000)

Three key areas formed the focus of public debate on Mäori and the Bill. These were:

3 Purpose

(1) The purpose of this Act is to provide for the public funding and provision of personal health services, public health services, and disability support services, and to establish new public health organisations, in order to ----
...

(d) consistently with the purposes specified in paragraphs (a) to (c), recognise and respect the principles of the Treaty of Waitangi

4 Treaty of Waitangi

This Act is to be interpreted in a manner consistent with the principles of the Treaty of Waitangi

14 Functions of DHBs

(4) To Establish and maintain partnership relationships between the board of the DHB and mana whenua (New Zealand Public Health and Disability Bill 48-1 (2 August 2000))

Debate on these was not long in coming.

## Response to Treaty Clauses

In the debate that surrounded the proposed legislation there were arguments put forward that suggested that the increased recognition of the Treaty of Waitangi in health over the last two decades had not taken place. For example, the Race Relations Conciliator took a strong stand in opposition to the Treaty clauses when making his submission to the select committee, as outlined in the following paragraphs. Despite the new government's stated (Labour Party, 1999, Part 1, & Turia, Lecture, 7 July 2000) pre and post election intentions to have a Treaty based approach to health legislation as part of their 'closing the gaps' strategy to reduce disparity between Mäori and non-Mäori they did not deliver. The Public Health and Disability Act 2000 was initially proposed to be more Treaty specific than the 1993 legislation had been. However, what appears to have occurred was a clawing back to maintaining the status quo.

The Race Relations Conciliator made a submission to the Parliamentary Health Select Committee on the Government's proposed health legislation. It argued that the proposed legislation should not be biased towards Mäori on the basis of the Treaty of Waitangi as it would be discriminatory towards non-Mäori.

The conciliator raised three separate areas of concern. He objected to the inclusion of the Treaty on the grounds of its divisiveness, and also on the grounds that it would privilege Mäori ahead of other New Zealanders.

> The Conciliator recommends the removal of clause 4. Including the direction that the legislation is interpreted in a manner consistent with the principles of the Treaty of Waitangi could be unduly divisive and would not promote positive race relations in New Zealand. This is particularly important in view of the acknowledgment that the implications of the Human Rights Act 1993 have not been fully considered. There have been concerns with section 44 in the past as it relates to health services. It cannot be assumed that section 73 will always apply and, if does, whether it is appropriate.
>
> The Conciliator agrees that it is appropriate to adopt measures which will address Mäori poor health. However, this should not be at the expense of other New Zealanders. There are better ways of addressing this, for example, targeting high-risk groups. If there are a disproportionate number of Mäori within those groups, then they stand to benefit from the measure in greater numbers (Race Relations Conciliator, 2000, p12)

He also objected to the appointment of Mäori to District Health Boards on any other grounds but that of their skill and knowledge.

> The Conciliator is not opposed to requiring specific Mäori representation on District Health Boards, but those appointed should be appointed for their particular skills and knowledge of the health area rather than because they are Mäori (Race Relations Conciliator, 2000, p12)

All three objections miss much of the debate around the role of the Treaty in health, and the Treaty's legal status as I have argued in chapter 2. The fact that the Treaty is a point of division is only a reflection of the fact that New Zealand is not a monocultural society, though at times its institutions behave as though it is. Mäori simply do not have the same health status as that of other New Zealanders, and are arguably a high-risk group. Health rationing on any group's behalf (say people suffering from diabetes) is always going to be at the expense of other New Zealanders.

The third objection completely misses the possibility of Mäori participating with the Crown in a partnership on District Health Boards. Needless to say, that possibility has not come to fruition.

Mäori similarly challenged the notion of mana whenua, seeing this as a coinage to avoid the difficult issue of the relationship between tangata whenua and urban Mäori and their varying aspirations.

## The Treaty in the Act

The challenges to the Bill led to a substantial watering down of its provisions in the finally enacted Health and Disability Services Act 2000. The purpose no longer made reference to the Treaty of Waitangi, clause 4 focused on a much narrower application of the Treaty, and the notion of partnership with mana whenua was reduced to ensuring Mäori could continue to participate and build capacity.

> 3 Purpose
>
> (1) The purpose of this Act is to provide for the public funding and provision of personal health services, public health services, and disability support services, and to establish new publicly-owned health and disability organisations, in order to pursue the following objectives:
>
> (a)...
>
> (b) to reduce health disparities by improving the health outcomes of Mäori and other population groups:
>
> 4 Treaty of Waitangi
>
> In order to recognise and respect the principles of the Treaty of Waitangi, and with a view to improving health outcomes for Mäori, Part 3 provides for mechanisms to enable Mäori to contribute to decision-making on, and to participate in the delivery of, health and disability services.

23 Functions of DHBs

(1) For the purpose of pursuing its objectives, each DHB has the following functions:

(a)...

(d) to establish and maintain processes to enable Mäori to participate in, and contribute to, strategies for Mäori health improvement:

(e) to continue to foster the development of Mäori capacity for participating in the health and disability sector and for providing for the needs of Mäori:

(f) to provide relevant information to Mäori for the purposes of paragraphs (d) and (e): (New Zealand Public Health and Disability Act 2000)

## Fit with Closing The Gaps

The 1999 Labour/Alliance coalition government was being challenged on a number of fronts in respect of Mäori issues. The cornerstone policy of "Closing the Gaps" (Turia, Lecture, 7 July 2000) had come under increasing fire as the Minister of Mäori Affairs proved unable to withstand pressure to resign over allegations of improper behaviour. The Associate Minister of Health also came under public criticism, when she likened the effects of colonisation on Mäori to the Holocaust in Nazi Germany (Hill, 30 August 2000)

By April 2001 the "Closing the Gaps" brand was firmly consigned to history. Mark Prebble, Chief Executive of the Department of the Prime Minister and Cabinet, wrote to chief executives of the state sector advising:

> At the Cabinet Policy Committee on 10 April 2001, ministers agreed to the rewording of two of the government's key goals.
>
> Ministers have asked me to emphasise that the revisions, which relate to references to "closing the gaps", do not represent any change to the substance of government policy. All chief executives remain accountable for the range of goals, plans and intentions that the government has laid out over its term in office (Prebble, 2001)

Key government goals had been restated in greatly watered down terms. The government would endeavour to uphold the Treaty of Waitangi, and reduce social inequality.

> KEY GOVERNMENT GOALS TO GUIDE PUBLIC SECTOR POLICY AND PERFORMANCE
>
> • Strengthen National Identity and Uphold the Principles of the Treaty of Waitangi
>
> Celebrate our identity in the world as people who support and defend freedom and fairness, who enjoy arts, music, movement and sport, and who value our cultural heritage; and resolve at all times to endeavour to uphold the principles of the Treaty of Waitangi.
> ...
>
> • Reduce Inequalities in Health, Education, Employment and Housing
>
> Reduce the inequalities that currently divide our society and offer a good future for all by better co-ordination of strategies across sectors and by supporting and strengthening the capacity of Mäori and Pacific Island communities (Prebble, 2001)

A government under increasing public pressure had abandoned any special focus on the needs of Mäori as indigenous people, as a unique ethnic group in New Zealand.

# APPENDICES

## Appendix 1: CCMAU Treaty Obligations in SOE

In 1999 the Mäori Health Commission developed policy with CCMAU to include Treaty-based obligations in the annual set of expectations. The 1999 Statement of Expectations from the Shareholding Ministers refers for the first time to principal objectives and performance expectations of HHSs for Mäori health (see Appendix III).

***Mäori Health***

***Principal objective***

*The Crown's overall objective for Mäori health is to improve Mäori health status so that Mäori have the opportunity to enjoy the same level of health as non-Mäori.*

*It is the responsibility of the HFA in making purchase decisions to ensure that Mäori people are able to access health services relative to their needs.*

*In contracting with them, we expect you to work with the HFA and with other providers to develop and improve health services that can effectively address Mäori health priorities.*

***Performance expectations***

***Inclusion of Mäori advice at board and management levels***

*When making decisions that will impact on the delivery of health services to Mäori as customers we encourage you to seek appropriate advice.*

*In accordance with good practice such decisions will normally take into account:*

- *your HHS purchase contract requirements;*
- *the cultural perspectives of Mäori as consumers of your health care services,*
- *your organisational capacity to respond appropriately and effectively to those customer needs, and*
- *any constraints encountered in integrating and responding to advice on the needs of Mäori people, as consumers of your health care services.*

Mäori customer satisfaction

*We expect you to continue to ensure that customer satisfaction among Mäori is recognised as an integral part of good business practice.*

***Communications with Mäori providers and with Mäori customers***

*As part of the effective conduct of your business, it is necessary that you maintain appropriate links with Mäori customers and Mäori providers within your service areas. We expect you to work with the HFA to ensure that Mäori patients and communities receiving the services of your HHS are kept informed of those services and initiatives. Where applicable you should engage in appropriate consultation processes with Mäori, particularly where your contracts with the HFA require you to:*

*i. develop new services that will impact on Mäori customers;*
*ii modify (where necessary) existing services in a way that will impact on Mäori customers; or*
*iii seek joint ventures or other collaborative arrangements with Mäori organisations or providers for the provision of health services to Mäori.*

***Reporting Requirements***

*Your business plan should specify your existing health services and new initiatives that are relevant to your Mäori customers.*

*In recognition of HHS responsibilities to Mäori as customers and the HFA's responsibilities to Mäori communities, we expect HHSs to report on activities relevant to advancing the Government's goal for Mäori health in your SOI.*

# Appendix 2: Health Funding Authority Mäori Health Policy

(Health Funding Authority, National Strategic Plan for Mäori Health 1998-2001, p59,60)

The Health Funding Authority developed a Mäori health policy for the organisation specific to their role as purchasers. The purpose of the policy was defined as "to identify and implement a proactive HFA response to Mäori health gain issues and development." (Health Funding Authority, HFA Mäori Health Policy 1998/99, p1). The policy separated the ownership (internal) and performance (external) issues.

The key internal issues identified in the policy are:

Strategic Business Planning

Ensure that all HFA strategic and business plans explicitly provide for the ways and means by which Mäori health gain objectives shall be achieved.

Financial Accountability (Funding Allocations)

Ensure that the HFA identifies the amount of funding allocated to both mainstream and other services for the benefit of Mäori and applies additional resources based upon issues of equity and need.

Personal Accountability (Employment Contracts)

Ensure all HFA employment contracts (including those with independent consultants) incorporate a standard Mäori Health/Treaty clause in addition to a series of measurable performance goals and objectives. A recommended clause follows:

> Given that the Crown regards the Treaty of Waitangi as New Zealand's 'founding document' and that Mäori Health is a Crown Health Gain Objective, the Employee/Consultant shall ensure that in every aspect of employment with the HFA, all Mäori health strategies, principles, policies, and practices approved by the HFA Board, shall be implemented in a pro-active and duly diligent manner.

Collective Accountability

Ensure that all HFA Executive Management Team decisions impacting upon Mäori health give full regard to, and implement the Mäori health strategies, principles, policies and practices approved by the HFA Board in a proactive and duly diligent manner.

Mäori Workforce Development

Ensure that the HFA Human Resource policies and employment practices encourage the active recruitment, retention and continuous quality training of Mäori staff at all levels of the organisational structure.

Indigenous Matrix Management System

Ensure the implementation of an Indigenous Matrix Management System which provides for the strategic placement of Mäori personnel within the HFA operational structure.

Key external issues:

Relationships with Mäori

Ensure that the HFA gives full regard to building relationships with Mäori which provide the opportunity for Mäori to contribute, in association with the HFA, to the development of principles and practices which improve Mäori health status.

Mäori Provider Development

Mäori Provider Development and its contribution to improved access and choice of services for Mäori, is supported by the HFA Board as a necessary element of the health sector. Therefore, approved Mäori providers' shall receive the developmental support of the HFA which may include managed access to the human, technological and financial resources of the HFA. Therefore the CEO shall:

Ensure Mäori providers receive access to the developmental support of the HFA.

Mainstream Enhancement - Contract Clauses (particularly relevant to HHS contracts)

Ensure that the HFA contracts include a statement concerning the HFA's position on the Treaty of Waitangi and Mäori Health.

Ensure that HFA contracts include a Mäori Health clause requiring the provider to specify how it intends to implement "The Treaty of Waitangi and Mäori Health" statement.

Strategic Dialogue

Ensure that the HFA initiates dialogue with the HHS shareholder regarding Mäori health policies and appointments of Mäori personnel to HHS Boards.

Monitoring Mechanisms

Ensure that the HFA defines and implements performance accountabilities within provider contracts which allows for monitoring, evaluation and contract re-definition in order to achieve Mäori health gains.

# Appendix 3: Mäori Health Cabinet Papers

**Overview and Treaty of Waitangi (2000, http://www.executive.govt.nz/minister/king/cabinet00-08/index.html)**

**HON ANNETTE KING, MINISTER OF HEALTH**

MEMORANDUM TO CABINET SOCIAL POLICY AND HEALTH COMMITTEE

**THE GOVERNMENT'S POLICIES FOR MÄORI PARTNERSHIP AND PARTICIPATION**

Four Cabinet papers being released today set out the Government's policy with regard to partnership with Mäori and Mäori participation in the District Health Boards. The Government's overall aim is to:

- acknowledge the principles of the Treaty of Waitangi
- protect gains already made in Mäori provider development
- move forward, to strengthen Mäori provider and workforce development, to improve mainstream service responsiveness to Mäori, and to close gaps between the health of Mäori and other populations.

**The Treaty of Waitangi in the New Zealand Health and Disability Bill**

- The Government has decided there will be a reference to the Treaty of Waitangi in the New Zealand Health and Disability Bill to give legal effect to the Government's commitment to the principles of the Treaty
- There will be a general reference of a high level nature in the Bill when it is introduced, while further work is done to specify how the Government will give effect to its commitment in more detail
- The more detailed work will not be completed in time for the introduction of the Bill, so will incorporated into policies, guidelines, protocols or other mechanisms.

**Partnership between Mäori and the Crown**

- There will be partnership arrangements between Mäori and the Crown at all levels of the health and disability sector. While there is an expectation that

relationship arrangements be established at each level, there will be flexibility about how this is done, since the characteristics and needs will be different from area to area.

- At the DHB governing board level, there will be Treaty-based partnership agreements between the board and the mana whenua of the region. The purpose of these agreements will be to ensure iwi are able to participate strategic planning to improve the health of, Mäori in the area
- Existing relationship agreements between the HFA and local iwi will be rolled over to the DHBs until they can be replaced with more appropriate arrangements, and DHBs will be required to develop relationship agreements in areas where there are none
- DHBs will be able to establish Mäori health advisory committees or other advisory mechanisms where appropriate
- At the DHB operational level there will be memoranda of understanding and other agreements between the DHB and Mäori. The aim is to continue to build Mäori capacity to provide for their own health and disability needs, and to continue to improve mainstream service responsiveness to Mäori
- Mäori service providers will continue to work with the DHBs, Mäori Development Organisations and mainstream providers to improve service delivery to Mäori.
- It is envisaged that these Mäori health and disability organisations will evolve over time, increasingly taking on responsibilities as their capacity grows, and potentially evolving into holistic organisations responsible for a range of services for Mäori, not just health
- At the national level, there will be a new national Mäori health forum, intended to provide a route for Mäori to discuss with Ministers and the Ministry of Health issues of strategic importance to Mäori health, and to have a say in national policy that impacts on Mäori health. The forum will not replace other means for Mäori to provide advice on national health policy issues by will provide a regular forum to supplement other ad hoc consultation and advisory arrangements.

**Mäori representation on DHB Boards**

- There will be at least two Mäori members on each DHB governing board, with additional Mäori members where necessary to reflect the proportion of Mäori in the DHB population. This will be achieved through a

fairer DHB voting system, the Single Transferable Voting system (STV) - a proportional voting system which is likely to achieve better representation of minority groups, including Mäori - with the results of the elections supplemented with Ministerial appointments to achieve the required levels of Mäori representation. Each DHB governing board will have seven elected members and up to four appointed members.

**HON ANNETTE KING, MINISTER OF HEALTH**

MEMORANDUM TO CABINET SOCIAL POLICY AND HEALTH COMMITTEE

**TREATY OF WAITANGI IN HEALTH LEGISLATION PROPOSAL**

This paper compares three options in relation to the inclusion of a reference to the Treaty of Waitangi in the New Zealand Public Health and Disability Bill:

no clause
a generic clause
a clause with greater specificity.

I recommend that a generic clause be agreed to, with the precise wording to be drafted by the Parliamentary Counsel's Office in consultation with the Crown Law office.

**EXECUTIVE SUMMARY**

Ministers have indicated their support for the inclusion of a Treaty clause in the NZ Public Health and Disability Bill to affirm and give coherence to the Government's commitment to the partnership between Mäori and the Crown, to maintaining Mäori confidence in the health sector, and to accelerating progress towards parity between Mäori and non-Mäori health.

Given the precedent that such a clause might set for other social service legislation, the paper compares the risks and benefits of the inclusion of such a clause with the risks and benefits of having no Treaty clause.

The most powerful argument for having no Treaty clause is the reduced risk to the Crown of litigation. The introduction of a specific reference to the Treaty in legislation carries with it a statutory responsibility to meet Treaty responsibilities. A moral responsibility becomes a legal responsibility.

The paper concludes that the risk of litigation is not a sufficient reason to omit a Treaty clause from the

legislation.

The inclusion of a Treaty clause is a principled policy response - both to the Government's Treaty obligations and to its explicit commitment to significantly improving Mäori health.

The merits of a simple generic clause are compared with those of a clause with greater specificity.

I recommend the inclusion of a simple generic clause. While a Treaty clause with greater specificity has an intuitive appeal, there is [a] some difficulty in coming to an agreement as to what should be specified, [b] a risk of becoming over prescriptive and thus limiting the development of genuine partnership, and [c] locking agencies into actions that may be inappropriate in some settings, or over time.

**BACKGROUND**

At their meeting on 19 April 2000, the Ad Hoc Ministerial Committee on Health Sector Change considered a paper canvassing the issues arising from the inclusion of a reference to the Treaty in health legislation. While Ministers supported such an inclusion, it was agreed that, given the precedent that the health legislation might set for future social service legislation, further work on the Government's position on the inclusion of a reference to the Treaty clause in social service legislation should be undertaken. This paper reflects that work.

This paper complements several other areas of work that are relevant to the application of the Treaty of Waitangi in the health sector, particularly relating to the principles of participation, partnership and protection. These include:

- equitable representation of Mäori on DHB Boards [CAB (00) M 2/4] An accompanying paper provides advice on how this could be achieved.
- Treaty-based partnership arrangements between Mäori and the Crown and between iwi and DHBs [CAB (00) m 11/1A(4)]. An accompanying paper sets out more implementation details.
- the objectives, goals and targets for Mäori health included in the draft New Zealand Health Strategy.

**WHY CONSIDER A TREATY CLAUSE?**

As Crown Law advisers have pointed out[1], arguments about special treatment for Mäori can be made whether or not there is a specific Treaty clause in legislation. Governments in recent years have implicitly and explicitly recognised the need for policy

responses to mitigate the disparities that exist between Mäori and non-Mäori and for Mäori provider development in a range of sectors. For some time now, even where there is no legislative reference to the Treaty of Waitangi, Courts have tended to refer to the principles of the Treaty as an aid to statutory interpretation in matters of particular concern to Mäori. Crown Law cites the High Court's decision in Barton-Prescott[2] as a case of interest 'because it moves further toward making the Treaty a mandatory relevant consideration for decision makers in areas where the court considers relevant Mäori interests are affected."

The Government may, however, include a Treaty clause where it wishes to:

- affirm the Treaty, and/or
- give legal effect to particular Treaty- based entitlements.

Ministers have already indicated that they wish to include a Treaty clause in the New Zealand Public Health and Disability Act - in effect affirming and bringing coherence to the Government's policy commitment to:

- ensuring an effective partnership between Mäori and the Crown in the health and disability sector
- maintaining Mäori confidence in the restructured health sector
- accelerating progress towards parity between Mäori and non-Mäori health.

Since there are no precedents thus far in social service legislation, and since a decision in this particular instance may set a trend for future legislation, this paper compares the risks and benefits of the inclusion of a Treaty clause (of two different levels of specificity) with the risks and benefits of the exclusion of such a clause.

**OPTION ONE: NO CLAUSE**

Under this option, there would be no specific reference to the Treaty of Waitangi in the Act. Instead, the Government's intentions with respect to Mäori health would be conveyed through other means: i.e. specific clauses in the New Zealand Public Health and Disability Act which set out the Government's intentions for Mäori without reference to the Treaty; the goals, targets and service priorities for Mäori in the NZ Health Strategy and the NZ Disability Strategy; and through the funding agreements with individual DHBs.

*RISKS*

***The Government's commitment to Mäori [issues] will be perceived as being lacking.***

Mäori expectations have been raised by Government manifesto and policy statements in relation to Mäori. Omission of any reference to the Treaty in legislation will be deeply disappointing to Mäori, particularly those in the health sector who have argued for such inclusion for some time. The omission may of itself be perceived as a breach of the partnership and protection principles of the Treaty.

***The lynch pin of the "model for partnership" will be missing***

The model for partnership at each level of the health system [described in CAB(00) 11/1A (4) and accompanying paper] will lack its key element. The Treaty of Waitangi underpins that model, and Mäori expect that the Treaty will underpin their relationship with this Government.

***Mäori may increasingly seek to address health status issues through the Waitangi Tribunal***

The Waitangi Tribunal may more frequently be called upon to fill what might be perceived to be a policy vacuum, directing the Government in respect of its obligations to Mäori health.

*BENEFITS*

***The Crown will have less exposure to the risk of litigation***

With the introduction of a specific reference to the Treaty into legislation, a statutory responsibility to meet Treaty obligations ensues. As Crown Law notes "maintaining the status quo does not alter the legal risk from the present situation. The issue becomes a policy one as to whether this [position] is adequate from the Treaty perspective."[3]

**Comment**

The omission of a specific reference to the Treaty in the health legislation would not diminish the Government's responsibility in relation to Mäori health development. Nor would it limit the Government's ability to require health sector agencies to take account of those responsibilities. However, omission of any reference to the Treaty would be interpreted by Mäori as indicative of a less than whole-hearted commitment to the principle of partnership and as such could be seen to be making a negative contribution to Mäori health and well being.

**Footnote(s):**

1

Advice to Ministry of Justice (1996); Draft Advice to Treasury (1997); Advice to Ministry of Health (April 2000)

2

a child custody case ,where the well-being of a whänau was at stake

3

Crown Law Advice to Ministry of Health, May 2000

**HON ANNETTE KING, MINISTER OF HEALTH**

MEMORANDUM TO CABINET SOCIAL POLICY AND HEALTH COMMITTEE

**TREATY OF WAITANGI IN HEALTH LEGISLATION CONTD**

**OPTION TWO: A GENERIC TREATY CLAUSE**

A 'generic' clause is a general reference to the Treaty of Waitangi without further specification of processes or actions that will occur in the context of acknowledgement of the Treaty.

Two examples of 'generic 'clauses are Section 4 of the Conservation Act (1987) and Section 9 of the State Owned Enterprises Act (1986):

*This Act shall be so interpreted and administered to give effect to the principles of the Treaty of Waitangi." [Conservation Act]*

*"Nothing in this Act shall permit the Crown to act in a manner that is inconsistent with the principles of the Treaty of Waitangi." [SOE Act]*

The Treaty clause in the draft Te Puni Kökiri legislation is a current variation:

*"This Act must be interpreted in a manner that is consistent with the principles of the Treaty of Waitangi."*

Crown Law advises that important legal consequences flow from the different wording used in the various generic clauses. If Ministers agree to a generic clause, it is proposed that, with the assistance of the Crown Law Office, the Parliamentary Counsel Office draft the form of words that most appropriately gives effect to the Government's policy intention (summarised in para 3 above).

*RISKS*

***Inclusion of any Treaty clause lowers the threshold for litigation***

Inclusion of a Treaty clause in legislation gives legal weight to Mäori aspirations in relation to health:

*"Conversion of previously unenforceable Treaty obligations into those of an enforceable kind by way of a statutory reference will increase rather than reduce litigation if for no other reason than the fact that there is thereby made available an independent accountability mechanism. If it is a general clause that requires compliance with Treaty principles, litigation is even more likely as the nature of the Treaty obligation (as well as whether the standard is met on the facts) is left open to the courts to decide in particular circumstances." [Crown Law, April 2000]*

Mäori will no longer be limited to the Waitangi Tribunal in seeking redress for perceived inadequacies in health care. It is difficult to predict the extent to which litigation may occur, although there may be some initial 'testing of the waters' for the purpose of establishing the bounds of the law. This would direct resources from other areas of health and disability funding but could be considered a desirable constitutional process.

Following the pattern of claims to the Waitangi Tribunal, it is likely that challenges will be seen in two main areas: Mäori control over their own health resources under Article 2, and claims that the Crown has failed to actively protect Mäori health status compared to other New Zealanders under Article 3[4].

***A generic clause may mean that Treaty principles are applied in unexpected ways***

It might be argued that without greater specificity as to the Crown's intention in relation to Mäori health, courts may interpret Treaty principles in ways that the Government did not intend:

*"There is of course a risk that the Courts acting under such a clause could interpret or apply Treaty principles in unexpected ways or in ways that have results that are difficult to foresee. However, given the relatively limited nature of the Courts functions on judicial review and their reluctance to intervene in matters of resource allocation, clinical judgement or decisions with a high policy content, I consider the risk relatively low." [Crown Law, May 2000]*

***Mäori will be seen to have claims upon the health system over and above those they share as citizens.***

The insertion of a Treaty clause is acknowledgement that Government accepts that Mäori do have claims upon the health system in addition to those that they have

as citizens, which relate to their status as indigenous people and Treaty partners, and their desire to have a say over the delivery of their own health and disability services.

***A generic Treaty reference may be seen as a token gesture.***

Lacking greater specificity about the Crown's intentions in regard to Mäori health, a generic clause may be viewed by some Mäori as merely a mantra, without much significance. But any Treaty clause-generic or specified - will be just one element of a comprehensive policy approach to Mäori health. The Government's goals, targets and priorities for Mäori health are detailed in the NZ Health Strategy; the proposal that a Treaty-based partnership model form the basis of relationships between Crown and Mäori at all levels of the health system is detailed in an accompanying paper; the Government's commitment to equitable representation of Mäori on the DHB Boards is the subject of the third paper in this suite. All of these commitments will be given direction and weight in both the legislation and the funding agreements that the Minister of Health will enter with DHBs.

*BENEFITS*

***A reference to the Treaty acknowledges the Government's commitment to Mäori as its Treaty partner.***

By taking this step of opening the door to enforcement in law of the Crown's responsibility to Mäori the Government is making its commitment to Mäori aspirations in health clear. It moves forward from the status quo (a reference in current legislation to the 'special needs of Mäori') with *"a relatively low risk that the Courts would imply a substantive shift in jurisdiction in the absence of clear statutory terms". [Crown Law]*

***A generic clause enables an evolutionary approach to partnership and participation in the health sector***

While it may be argued that a generic clause leaves questions unanswered as to what the Treaty of Waitangi means for the health sector in the 21st century, it might more persuasively be argued that it is better not to prescribe the answers in legislation, but rather leave them to be developed by Mäori and non-Mäori working in partnership in the health sector.

**Comment**

The inclusion of a generic Treaty clause in the health

legislation will lower the threshold for litigation, although much will depend on the actual words used in the clause. However it is unlikely to give rise to any substantive shift in jurisdiction or responsibility for policy, resource allocation or clinical decision-making. Inclusion of a Treaty clause will signal the Government's clear commitment to Mäori as its Treaty partner and to the importance it attaches to addressing the fundamental causes of Mäori ill-health.

**OPTION THREE: A TREATY CLAUSE WITH GREATER SPECIFICITY**

This option would see a general reference to the Treaty of Waitangi, with a more detailed specification of how the principles of the Treaty would apply at various levels of the health sector.

*RISKS*

***There is difficulty in deciding what to specify***

In moving from an elaboration of principles into specifying how they will operate in practice, there is a fine balance between being under prescriptive and over prescriptive. Articulating the principles of the Treaty is relatively easy, but operationalising them across all areas of the health sector may be viewed as an attempt to create an instruction book. At that point, the limiting aspect of specification becomes clear. It may be difficult to arrive at a consensus as to what should be specified (process or outcomes?), there are too many processes to specify, and Governments have too few levers to control (and thereby guarantee) outcomes.

***Specificity creates its own risks***

Specifying a particular process may lock agencies into actions that may be (a) inappropriate in some settings or locations and (b) difficult to adapt over time and to changing priorities. More appropriate practices might be open to legal challenge simply because they were outside specification. Once law, processes are not readily changed.

*BENEFITS*

***A more detailed clause would clarify how the Government interprets its undertakings with respect to the Treaty***

It is argued that there is a need for greater clarity as to how the principles of the Treaty should be applied in the health sector. It is envisaged that this clause would spell out for the benefit of the sector just how the principles of participation, partnership and protection would be applied in practice throughout the

sector.

***A more substantial signal of Government's commitment is given to Mäori***

Many Mäori are seeking evidence of a more practical commitment to improving Mäori health than a generic Treaty clause is perceived to deliver. The more that is specified in legislation, it is argued, the faster the results. However this is not a universal view. Different expectations and interpretations of the Treaty of Waitangi exist from community to community. Some Mäori may prefer an open interpretation of the Treaty as opposed to one negotiated by the Government.

***There is a greater incentive to comply with principles that are spelled out in legislation***

DHBs and other health agencies might move more quickly to meet specific legal responsibilities to their Mäori constituency once legal redress is possible.

***Greater specificity would give courts more guidance in any litigation involving Mäori health issues***

At present, courts refer to other legal interpretations of Treaty principles for guidance in matters where Mäori interests are at stake. Spelling out the Government's intentions in relation to Mäori health issues might give greater assistance to the judiciary in making determinations in the area of health.

**Comment**

A Treaty clause with a more explicit set of accompanying obligations has an intuitive appeal, in that the Government is seen to be giving a clearer exposition of what it interprets its Treaty obligations in the area of health to be. However, in going beyond a statement of the principles that will underpin the operation of the public health service, the risk of limiting the development of genuine partnership by over-prescription becomes clearer. The legislation should aim to enable, rather than to control, Mäori health development. There are other accountability mechanisms that can be brought to bear to achieve the Government's Mäori health objectives.

**Footnote(s):**

4

A review of some of the legal issues and risks that might arise based on recent claims to the Tribunal was canvassed in the Crown Law advice of 4 April 2000 paragraphs 26-39.

# Appendix 4: Waikato University Ethics Committee Approval

**Waikato**
**Ethics Committee**
P.O. Box 322
Hamilton
Phone (07) 846 1539
Fax (07) 846 1496
Email: wai.ethics@clear.net.nz

22 December 2000

Lisa Ferguson
D/3, 137 Alexandra Street
HAMILTON

Dear Lisa

**Health reform and the impact on Maori 1983-1997**
**(Our ref: 77/00/729)**

This proposal was considered by the Committee at its meeting on 20 December 2000 and given ethical approval. Thank you for amending the Consent form and for clarifying the approach you will take in respect of the oral interviews of participants.

Ethical approval is conditional upon the Committee receiving annual progress reports on the study, a final report at the completion of the study, and a copy of any publication. Please notify us if the study is abandoned or the protocol changed in any way.

Best wishes for the success of your study.

Yours sincerely

Rosemary J De Luca
Chairperson

# BIBLIOGRAPHY

## 1. PRIMARY SOURCES.

***Interviews were conducted with the following participants:***


Anderson, Steve; Principal Adviser, Health, CCMAU, Wellington, 12 March 1999.
Bednarek, Dr. Simon; President, Hawke's Bay Branch, New Zealand Medical Association, Napier, 13 January 1999.
Braybrooke, Geoff; MP, Napier, 25 January 1999.
Bunkle, Phillida; MP, Alliance Spokesperson on Health, Wellington, 16 and 19 February 1999.
Committee of the Mäori Women's Resource Centre; Napier, 19 January 1999.
Cullen, Michael; Deputy Leader, Labour Party, List MP for Napier, Wellington, 16 February 1999.
Davies, Lisa; Branch Manager, Monitoring and Evaluation, Te Puni Kökiri, Wellington, 12 March 1999.
Dick, Alan; Mayor of Napier, Napier, 19 February 1999.
Douglass, Hera; Policy Analyst, Ministry of Health, Wellington, 19 February 1999.
Fine, Brenda and Bernard Thompson; disbanded Hawke's Bay Health Council, Havelock North, January 25 1999.
Flowers, Mark; Chief Executive Officer, Healthcare Hawke's Bay, Napier, 5 February 1999.
Hay, James; Legal Adviser, CCMAU, Wellington, 12 March 1999.
Hodges, Wiremu; ex Mäori Health Manager, Healthcare Hawke's Bay, Napier, 20 January 1999.
Joe, Te Maari; Business Director, Te Kupenga Hauora, Napier, 26 August 1998.
Joe, Te Maari; Business Director, Te Kupenga Hauora, Napier, 26 January 1999.
Kirton, Neil; MP, ex Associate Minister of Health, Napier, 20 January 1999.
Kirton, Neil; MP, ex Associate Minister of Health, Wellington, 17 February 1999.
Macintosh, Alan; General Manager, City Medical, Napier, 19 January 1999.
Manaia, Wiremu, Ministry of Health, Wellington, June 1997.
Matatahi, Tutata, Primary Health Care Worker, Raukura Hauora O Tainui, Huntly, 11 July 1996 (for MA Thesis)
Orsborne, John and Barry Howell; General Manager and Operations Manager, Hawke's Bay Ambulance Service, Napier, 29 January 1999.
Taylor, Bevan; Chair of the Taiwhenua Office, Napier, 19 January 1999.
Taylor, Neil; Chief Executive Officer, Napier City Council, Napier, 5 February 1999.

Te Hemara-Maipi, Ramiri, Primary Health Care Worker, Raukura Hauora O Tainui, Huntly, 25th June 1996 (for MA Thesis)
Wilson, Walter; Healthcare Hawke's Bay Board Member, Mäori, Wairoa, 14 January 1999.

Interviews were conducted with officials of the following central agencies:

Treasury: Health Directorate, CCMAU
Ministry of Health, including Te Kete Hauora, Safety and Regulation Branch, and the Performance Monitoring Branch
Health Funding Authority: Mäori Health Group, Personal Health Group, Public Health Group, Clinical Training Agency, Te Tai Tokerau MAPO
Te Puni Kökiri

Accident Compensation Corporation
Commissioner for Children
Mäori Health Commission
Mental Health Commission
Ministry of Women's Affairs
Ministry of Youth Affairs
Work and Income New Zealand

Interviews or meetings were conducted with officials of the following provider agencies:

HHSs:
Crown Health Association
Auckland Healthcare
Canterbury Health
Capital Coast Health
Northland Health
Pacific Health

Non Government Organisations
Healthcare Aotearoa HCA
Platform
Pegasus IPA
The Royal New Zealand Plunket Society

Iwi/Mäori Providers
Ngai Tahu Development Corporation
Raukura Hauora O Tainui
Te Hauora O Te Tai Tokerau
Te Runanga O Nga Mata Waka

Eru Pomare Research Institute

*Focus groups*

First focus group, 9 participants, Taiwhenua office, Napier, 26 January, 1999
Second focus group, 15 participants, Mäori Women's Resource Centre, Napier, 27 January, 1999
Third focus group, cancelled by participants, Mäori Wardens, Napier, 4 February 1999

***Telephone interviews were conducted with the following participants:***

McLean, Wayne; Mäori Health Commissioner, Telephone interview, 9 March 1999

***Evidence presented at the Waitangi Tribunal Hearings into the Napier Hospital and Health Services (Wai 692) Claim.***

(the transcript used in this and subsequent references is an electronic copy of the evidence presented at the 12th hearing of the Mohaka Ki Ahuriri Inquiry, The Napier Hospital and Health Services Report, Waitangi Tribunal, p416)

Chris Clark, Team Leader, Targeted Assistance Group, CCMAU, evidence for the Crown concerning Napier Hospital Services Claim, Waitangi Tribunal July 29 1999

Colin Feek, Chief Adviser, Medical, Ministry of Health, evidence for the Crown concerning Napier Hospital Services Claim, Waitangi Tribunal July 29 1999

Mara Andrews, Senior Mäori Planning Manager, Health Funding Authority, evidence for the Crown concerning Napier Hospital Services Claim, Waitangi Tribunal July 30 1999

Ria Earp, Deputy Director general, Mäori Health, Ministry of Health, Brief of Evidence, Waitangi Tribunal, Wai 692 Hearing, W16, 9 July 1999

Ria Earp evidence for the Crown concerning Napier Hospital Services Claim, Waitangi Tribunal July 30 1999

Ria Earp cross examination of evidence for the Crown concerning Napier Hospital Services Claim, Waitangi Tribunal July 30 1999

Mark Flowers, Chief Executive, Healthcare Hawke's Bay, evidence for the Crown concerning Napier Hospital Services Claim, Waitangi Tribunal August 2 1999

Tribunal questioning of Crown Witness Mark Flowers, evidence for the Crown concerning Napier Hospital Services Claim, Waitangi Tribunal August 2 1999

Tribunal questioning of Crown Witness Peter Wilson,, Chairman, Healthcare Hawke's Bay, evidence for the Crown concerning Napier Hospital Services Claim, Waitangi Tribunal August 2 1999

***Correspondence with author:***

Crown Company Monitoring Advisory Unit; Letter - Agreed Record of Meeting of 12 March 1999, Crown Company Monitoring Advisory Unit, Wellington, 1999

Davies, Lisa; Letter to Lisa Ferguson - Clarification of Health Services Monitoring Roles, Te Puni Kökiri, Wellington, 1999

Ferguson, Lisa; Fax to Richard Moorsom - 15 April 1999, Harrison Ferguson Associates, Hamilton, 1999

Ferguson, Lisa; Letter to Craig Linkhorn - 10 March 1999, Harrison Ferguson Associates, Hamilton, 1999

Ferguson, Lisa; Letter to James Hay (CCMAU) - 18 March 1999, Harrison Ferguson Associates, Hamilton, 1999

Ferguson, Lisa; Letter to Mark Flowers - 24 January 1999, Harrison Ferguson Associates, Hamilton, 1999

Ferguson, Lisa; Letter to Richard Moorsom - 14 March 1999, Harrison Ferguson Associates, Hamilton, 1999

Ferguson, Lisa; Letter to Richard Moorsom - 16 March 1999, Harrison Ferguson Associates, Hamilton, 1999

Ferguson, Lisa; Letter to Richard Moorsom - 19 March 1999, Harrison Ferguson Associates, Hamilton, 1999

Ferguson, Lisa; Letter to Richard Moorsom - 5 March 1999, Harrison Ferguson Associates, Hamilton, 1999

Ferguson, Lisa; Letter to Richard Moorsom - 8 March 1999, Harrison Ferguson Associates, Hamilton, 1999

Linkhorn, Craig; Fax - Care of Richard Moorsom - Request Dated 10 March 1999, For Information Requested by Napier City Council, Crown Law Office, Wellington, 1999

Flowers, Mark; CEO Healthcare Hawke's Bay E-mail, 1999

Gwynn, Robin; Letter to Lisa Ferguson - 6 April 1999, Napier, 1999.

Linkhorn, Craig; Faxed Letter to author - Napier Hospital Claim - Interview with CCMAU, Crown Law Office, Wellington, 1999

Linkhorn, Craig; Letter to author - Napier Hospital Claim - Access to Information held by CCMAU 20 February 1999, Crown Law Office, Wellington, 1999.

Linkhorn, Craig; Letter to author - Napier Hospital Claim - Outstanding Matters - 8 March 1999, Crown Law Office, Wellington, 1999.

Linkhorn, Craig; Letter to author - Napier Hospital Claim - Request for Information - 15 February 1999, Crown Law Office, Wellington, 1999

Linkhorn, Craig; Letter to author - Napier Hospital Claim - Request for Information Held by Healthcare Hawke's Bay., Crown Law Office, Wellington, 1999.

Linkhorn, Craig; Letter to author - Napier Hospital Claim - Request for Information dated 26 February 1999, Crown Law Office, Wellington, 1999.

Linkhorn, Craig; Letter to author - Napier Hospital Claim - Request for Information dated 10 February 1999, Crown Law Office, Wellington, 1999.

Linkhorn, Craig; Letter to author - Napier Hospital Claim - Request for Information Dated 24 January 1999, Crown Law Office, Wellington, 1999.
Linkhorn, Craig; Letter to author - Napier Hospital Claim - Request for Information Dated February 1999, Crown Law Office, Wellington, 1999.
Linkhorn, Craig; Letter to author - Napier Hospital Claim - Request for Information of 24 January 1999, Crown Law Office, Wellington, 1999.
Linkhorn, Craig; Letter to author - Napier Hospital Claim - Request for Information of 24 January 1999, Crown Law Office, Wellington, 1999.
Linkhorn, Craig; Letter to author - Napier Hospital Claim - Request for Official Information, Crown Law Office, Wellington, 1999.
Linkhorn, Craig; Letter to author - Request for Information (26 February, 10 and 12 March1999), Crown Law Office, Wellington, 1999.
Linkhorn, Craig; Letter to author - Request for Information Held by CCMAU and Healthcare Hawke's Bay, Crown Law Office, Wellington, 1999.
Linkhorn, Craig; A Faxed Report from Richard Moorsom that Originally Came from Crown Counsel RE: Lisa Ferguson and Napier Hospital Services Claim, Crown Law Office, Wellington, 1999.
Love, Morris T. W.; Letter of Introduction, Ms Lisa Ferguson from Waitangi Tribunal - 18 December 1998, Waitangi Tribunal, Wellington, 1998.
Moorsom, Richard; Faxed Memorandum to author in Reply to Her Memo to Waitangi Tribunal - Fax Sent 22 April 1999, Waitangi Tribunal, Wellington, 1999.
Moorsom, Richard; Letter to Craig Linkhorn (Copied to author) - Researcher Access to Government Agencies - 18 February 1999, Waitangi Tribunal, Wellington, 1999.
Quinliven, Michael, Fax to Lisa Ferguson from Health Funding Authority – Wai 692 Claim (Y692 sic), Health Funding Authority, Wellington, 1999.
Waitangi Tribunal; Terms of Reference for Lisa Ferguson - Contemporary Issues Report, Waitangi Tribunal, Wellington, 1998.

***Official Correspondence***

Bishop, Emily; Letter to Fred Reti - Next Five Years in General Practice - 26 June 1998, Health Funding Authority, Wellington, 1998
Bolger, Jim; Letter to Estelle Ward from Rt. Hon. J B Bolger - Prime Minister, New Zealand Government, Wellington, 1995
Bolger, Jim; Letter to H Lindsey from Rt. Hon J B Bolger - Prime Minister, New Zealand Government, Wellington, 1995
Bolger, Jim; Letter to Mrs. M V Blair from Rt. Hon Jim Bolger - Prime Minister, New Zealand Government, Wellington, 1995
Bowes, Alistair; Acute Hospital Task Force Faxed from Healthcare Hawke's Bay, Healthcare Hawke's Bay, Napier, 1993.
Central Regional Health Authority; Letter to Alan Dick - Napier Mayor Regarding the Process of Consultation, Central Regional Health Authority, Wellington, 1995
Collection of "Assurance" Letters from Government to "Concerned Citizens", New Zealand Government, Wellington, 1995,96
Coopers and Lybrand, Letter to CCMAU - Regional Hospital Proposal - Coopers and Lybrand Report, Coopers and Lybrand, , 1995

Crown Company Monitoring Advisory Unit, Briefing Note for Prime Minister's visit with Mayor of Napier, Crown Company Monitoring Advisory Unit, Wellington, 1996
Crown Company Monitoring Advisory Unit, Fax Letter to Ministers of Health and CHE - Healthcare Hawke's Bay 1995/96 Business plan review - Update, Crown Company Monitoring Advisory Unit, Wellington, 1995
Crown Company Monitoring Advisory Unit, Letter to Ministers - Review of the Healthcare Hawke's Bay Ltd. Business Plan 1998/99 - 2000/01, Crown Company Monitoring Advisory Unit, Wellington, 1998
Crown Company Monitoring Advisory Unit; Letter to Ministers - Healthcare Hawke's Bay Statement of Intent Targets for 1997/98, Crown Company Monitoring Advisory Unit, Wellington, 1998
Dick, Alan; Letter from Napier Mayor to Hon. Simon Upton – Hawke's Bay CHE Advisory Committee, Napier City Council, Napier, 1992
Dick, Alan; Letter to Minister of Finance and CHE from Napier Mayor, Napier City Council, Napier, 1995
East, Paul; Letter to Alan Dick - Mayor of Napier from Minister of CHEs, New Zealand Government, Wellington, 1995
East, Paul; Letter to Alan Dick - Napier Mayor from - Minister of CHE, New Zealand Government, Wellington, 1992
Edwards, B; Memo to Phillida Bunkle Including a four page resignation, New Zealand Resident Doctors' Association, Napier, 1998
English, Bill; Letter from Minister of Health to Healthcare Hawke's Bay and HFA - Napier Health Centre and Healthcare Hawke's Bay 1998/99 - 2000/01 Business Plan, New Zealand Government, Wellington, 1998
English, Bill; Letter to Wilson Wright from - Minister of CHE, New Zealand Government, Wellington, 1996
Flowers, Mark; Correspondence to and from Mark Flowers and Napier Mayor, Healthcare Hawke's Bay, Napier, 1997,98
Flowers, Mark; Fax letter to CCMAU - Healthcare Hawke's Bay Regional Hospital Project - Implementation Framework, Healthcare Hawke's Bay, Napier, 1995
Flowers, Mark; Letter to the Ministers of Finance and CHE, Healthcare Hawke's Bay, Napier, 1995.
Flowers, Mark; Memorandum to Directors and Executive from Neil Kirton Review Submission - 15 August 1997, Also Including the Submission to the Hawke's Bay Regional Hospital - Review of Consultation Process, Healthcare Hawke's Bay, Napier, 1997.
Healthcare Hawke's Bay; Letter from Healthcare Hawke's Bay to Justine Tringham (CCMAU)- Site for proposed Napier Health Centre Napier South Railway Land, Healthcare Hawke's Bay, Napier, 1998.
Healthcare Hawke's Bay; Letter to Bill English - Statement of Intent Targets 1997/98, Healthcare Hawke's Bay, Napier, 1998.
Healthcare Hawke's Bay; Letter to CEO of CCMAU - Results of Coopers and Lybrand's efficiency analysis, Healthcare Hawke's Bay, Napier, 1996.
Healthcare Hawke's Bay; Letter to Chris Jagger (CCMAU) - Summary of Issues, Healthcare Hawke's Bay, Napier, 1997.
Healthcare Hawke's Bay; Letter to Minister of Health - Healthcare Hawke's Bay - Business Plan - 13 March 1997, Healthcare Hawke's Bay, Napier, 1997.

Healthcare Hawke's Bay; Collection of Information on the Boards Decision - 2 Letters (29 March 1995) and (4 April 1995) and a Written Report of the Healthcare Hawke's Bay Board Meeting, Healthcare Hawke's Bay, Napier, 1995.

Healthcare Hawke's Bay; Covering letter and Copy of the Decision of the Board of Healthcare Hawke's Bay on the Establishment of a Regional Hospital for Hawke's Bay, Healthcare Hawke's Bay, Napier, 1995.

Henley, Geoff; Correspondence between Network Communications (New Zealand) Ltd and Healthcare Hawke's Bay - A Collection of Faxes. Memos Letters and Reports, Network Communications (New Zealand) Ltd, Wellington, 1994.

Henley, Geoff; Memorandum to Mark Flowers from Network Communications - Napier Services "Consultation", Network Communications (New Zealand) Ltd, Wellington, 1997

Hodges, Wiremu; Memo to Mäori Health Committee, Mäori Health Services - Bi-Monthly Report., Healthcare Hawke's Bay, Napier, 1997

Hodges, Wiremu; Memo to Mäori Health Committee, Mäori Health Services - Report for December 1997, Mäori Health Committee Meeting, Healthcare Hawke's Bay, Napier, 1997.

Joe, Te Maari; Letter to Taskforce - Submission on Regional Hospital Taskforce Report, Whanau Atawhai Mäori Women's Welfare League, Napier, 1994.

Laws, Michael; Letter to Paul East - Minister of CHEs from Michael Laws MP - RE: Audit Office Powers and Healthcare Hawke's Bay, Napier, 1995.

Laws, Michael; Memorandum to Minister of Health Simon Upton from Michael Laws Hawke's Bay MP - RE: Napier Hospital and Hawke's Bay Health Commission, Napier, 1992.

Moore, David; Letter to Alan Dick (Napier Mayor) from Regional Director (HFA) - Change to Future HFA Arrangements with Community Health Groups and Heath Councils in the Central Region, Health Funding Authority, Wellington, 1998.

Moore, Kevin; Fax to Healthcare Hawke's Bay Ltd. from Delnagairn - RE: Claim Wai 692 - Report Not Written, Delnagairn Investments Ltd., Napier, 1999.

Napier Hospital Retention Group; Fax to Hon. Jim Anderton, including Newspaper Clippings, Napier Hospital Retention Group, Napier, 1996.

Opus International Consultants; Letter - Appendix 8 - File Reference 25041509 - To CEO of Healthcare Hawke's Bay, Opus International Consultants, 1997.

Pohe, Rapai; Letter to Mäori Health Committee from Manager Corporate Health Services Healthcare Hawke's Bay - 25 February 1998, Healthcare Hawke's Bay, Napier, 1998

Pohe, Rapai; Memorandum to Mäori Health Committee - Bi-Monthly Report to Mäori Health Committee, Healthcare Hawke's Bay, Napier, 1997.

Sales, Lindsay, Internal Memo to Mike Ashby and Andrew Kiblewhite - CHE business plans - Canterbury and Hawke's Bay , CCMAU, 1995.

Shipley, Jenny, Letter from Minister of Health - Unknown recipient, New Zealand Government, Wellington, 1994.

Shipley, Jenny, Letter to Charles Carrel from Minister of Health, New Zealand Government, Wellington, 1994.

Shipley, Jenny, Letter to H Lindsey from Minister of Health, New Zealand Government, Wellington, 1995.

Shipley, Jenny, Letter to Margaret Curphey from Minister of Health, New Zealand Government, Wellington, 1995.
Shipley, Jenny, Letter to R Dean (Blacked out) from Minister of Health, New Zealand Government, Wellington, 1995.
Smith, Adrian, Memorandum to Andrew Weeks - Healthcare Hawke's Bay Visit Letter to Associate Minister of Health, 1997
Taylor, Neil; Letter to Sir Brian Elwood – Ombudsman's Office from Napier City Council CEO: Consultation - Napier City Council / Healthcare Hawke's Bay, Napier City Council, Napier, 1994
Upton, Simon; Letter to Alan Dick from Minister of Health, New Zealand Government, Wellington, 1992
Upton, Simon; Letter to Healthcare Hawke's Bay Board Chairman from the Minister of Health - Review of Services and Report on a Meeting with the Minister, New Zealand Government, Wellington, 1991.
Wilson, Peter; Collection of correspondence to Minister of Health - 12 September 1997, Healthcare Hawke's Bay, Napier, 1997
Wilson, Peter; Fax letter to Adrian Wimmers (CCMAU) - Copies of letters to the Ministers - Birch and English, Healthcare Hawke's Bay, Napier, 1994
Wilson, Peter; Letter to the Directors of Healthcare Hawke's Bay CCMAU - The Decision for Healthcare Hawke's Bay Ltd, Healthcare Hawke's Bay, Napier, 1994
Wilson, Peter (Chair, Healthcare Hawke's Bay Ltd.) Letter to Michael Laws, MP, 14 April 1994 (draft prepared by Network Communications)
Letter to Healthcare Hawke's Bay CEO from Manager of Mäori Health - Mäori Consultation Hui - Regarding Taskforce Report on Hawke's Bay Regional Hospital Issue, Healthcare Hawke's Bay, Napier, 1994.

***Reference material collected by the claimants:***

Bloomer, P. H .E; Letter from P H E Bloomer to Keith Sellars, Napier, 1994
Callinicos and Gallagher; Letter to Tom Hemopo from Lawyers - RE: Treaty of Waitangi Judicial Review - Healthcare Hawke's Bay LTD, Callinicos and Gallagher, Napier, 1994
Emery, Takuta Hohepa Mei, Brief of Evidence for the First Napier Hospital claim, Napier, 1998
Hemopo, Tom; Letter to Healthcare Hawke's Bay - re: Hospital Submissions, Napier, 1994.
Hemopo, Tom; Letter to the Napier Mayor re: Healthcare Hawke's Bay - Napier City Council Consultation, Napier, 1995.
Hemopo, Tom; Submission to Healthcare Hawke's Bay, Ltd., 1 June 1994.
Joe, Te Maari; Brief of evidence, 1994
Waaka, T; Correspondence from Te Taiwhenua o Whanganui A Orotu to Lawyers, Te Taiwhenua o Whanganui A Orotu, Napier, 1994
Waaka, Toru Edward; Brief of Evidence of Toru Edward Waka, Chairman, Te Taiwhenua O Te Whanganui A Orotu Inc, Napier, 1994.

Board Minutes

Hawke's Bay Area Health Board in Committee Minutes, 26 November 1990

Hawke's Bay Area Health Board Minutes Appendix E, Letter to A. Train from Minister of Health, Simon Upton, 13 December 1990.

Healthcare Hawke's Bay; Crown Health Hawke's Bay Limited - Minutes of Meeting of Board of Directors - 13 December 1993, Healthcare Hawke's Bay, Napier, 1993.

Healthcare Hawke's Bay; Crown Health Hawke's Bay Limited - Minutes of Meeting of Board of Directors - 2 March 1994, Healthcare Hawke's Bay, Napier, 1994.

Healthcare Hawke's Bay; Crown Health Hawke's Bay Limited - Minutes of Meeting of Board of Directors - 30 November 1993, Healthcare Hawke's Bay, Napier, 1993.

Healthcare Hawke's Bay; Crown Health Hawke's Bay Limited - Minutes of Meeting of Board of Directors - 8 April 1994, Healthcare Hawke's Bay, Napier, 1994.

Healthcare Hawke's Bay; Crown Health Hawke's Bay Ltd. - Minutes of Meeting of Board of Directors - 14 April 1994, Healthcare Hawke's Bay, Napier, 1994.

Healthcare Hawke's Bay; Crown Health Hawke's Bay Ltd. - Minutes of Meeting of Board of Directors - 14 February 1994, Healthcare Hawke's Bay, Napier, 1994.

Healthcare Hawke's Bay; Crown Health Hawke's Bay Ltd. - Minutes of Meeting of Board of Directors - 21 April 1994, Healthcare Hawke's Bay, Napier, 1994.

Healthcare Hawke's Bay; Crown Health Hawke's Bay Ltd. - Minutes of Meeting of Board of Directors - 4 May 1994, Healthcare Hawke's Bay, Napier, 1994.

Healthcare Hawke's Bay; Crown Health Hawke's Bay Ltd. - Minutes of Meeting of Board of Directors - 29 March 1994, Healthcare Hawke's Bay, Napier, 1994.

Healthcare Hawke's Bay; Minutes of Meeting of Board of Directors - 18 October 1993, Healthcare Hawke's Bay, Napier, 1997.

Healthcare Hawke's Bay; Minutes of Meeting of Board of Directors - 1 July 1994, Healthcare Hawke's Bay, Napier, 1994.

Healthcare Hawke's Bay; Minutes of Meeting of Board of Directors - 10 June 1994, Healthcare Hawke's Bay, Napier, 1994.

Healthcare Hawke's Bay; Minutes of Meeting of Board of Directors - 19 September 1993, Healthcare Hawke's Bay, Napier, 1993.

Healthcare Hawke's Bay; Minutes of Meeting of Board of Directors - 2 June 1994, Healthcare Hawke's Bay, Napier, 1994.

Healthcare Hawke's Bay; Minutes of Meeting of Board of Directors - 21 July 1994, Healthcare Hawke's Bay, Napier, 1994.

Healthcare Hawke's Bay; Minutes of Meeting of Board of Directors - 26 January 1994, Healthcare Hawke's Bay, Napier, 1993.

Healthcare Hawke's Bay; Minutes of Meeting of Board of Directors - 28 March 1995, Healthcare Hawke's Bay, Napier, 1995.

Healthcare Hawke's Bay; Minutes of Meeting of Board of Directors - 9 June 1994, Healthcare Hawke's Bay, Napier, 1994.
Healthcare Hawke's Bay; Minutes of the Meeting of CHE Board - 23 August 1994, Healthcare Hawke's Bay, Napier, 1993.
Healthcare Hawke's Bay; Minutes of the Meeting of CHE Board Designate - 19 April 1993, Healthcare Hawke's Bay, Napier, 1993.
Healthcare Hawke's Bay; Minutes of the Meeting of the CHE Board - 19 July 1993, Healthcare Hawke's Bay, Napier, 1993.
Healthcare Hawke's Bay; Minutes of the Meeting of the CHE Board Designate - 17 May 1993, Healthcare Hawke's Bay, Napier, 1993.
Healthcare Hawke's Bay; Minutes of the Meeting of the CHE Board Designate - 28 April 1993, Healthcare Hawke's Bay, Napier, 1993.
Healthcare Hawke's Bay; Minutes of the Meeting of the CHE Board Designate - 29 June 1993, Healthcare Hawke's Bay, Napier, 1993.
Hawke's Bay Area Health Board, Board Minutes, 26 March 1990
Hawke's Bay Area Health Board Minutes January 1991
Hawke's Bay Area Health Board May 1991 Minutes
Hawke's Bay Area Health Board May 1991 Minutes appendix M1, Letter from Minister of Health Simon Upton to A Train 12 April 1991
Healthcare Hawke's Bay Board Minutes, 29 June 1993
Healthcare Hawke's Bay Board Minutes, 2 June 1994

Committee Minutes

Hawke's Bay Hospital Board: Area Health Board Consultative Committee, Hawke's Bay Hospital Board, Napier, 1987.
Healthcare Hawke's Bay; Healthcare Hawke's Bay - Bi-monthly Service Report to the Mäori Health Committee - June 1997, Healthcare Hawke's Bay, Napier, 1997.
Healthcare Hawke's Bay; Mäori Health Committee - Management Summary, Healthcare Hawke's Bay, Napier, 1997.
Healthcare Hawke's Bay; Mäori Health Committee - Organisation and Management, Healthcare Hawke's Bay, Napier, 1997.
Healthcare Hawke's Bay; Mäori Health Committee - Service Overview, Healthcare Hawke's Bay, Napier, 1997.
Healthcare Hawke's Bay; Mäori Health Committee Meeting - 11 August 1997, Healthcare Hawke's Bay, Napier, 1997.
Healthcare Hawke's Bay; Mäori Health Committee Meeting - 13 October 1997, Healthcare Hawke's Bay, Napier, 1997.
Healthcare Hawke's Bay; Mäori Health Committee Meeting - 16 April 1998, Healthcare Hawke's Bay, Napier, 1998.
Healthcare Hawke's Bay; Mäori Health Committee Meeting - 6 June 1997, Healthcare Hawke's Bay, Napier, 1997.
Healthcare Hawke's Bay; Mäori Health Committee Meeting - 8 December 1997, Healthcare Hawke's Bay, Napier, 1997.
Healthcare Hawke's Bay; Mäori Health Committee Meeting - 9 February 1998, Healthcare Hawke's Bay, Napier, 1998.
Healthcare Hawke's Bay; Mäori Health Committee Meeting - June 1998, Healthcare Hawke's Bay, Napier, 1998.

Minutes of the Mäori Consultation Hui Regarding Taskforce Report on Hawke's Bay Regional Hospital Issue, Healthcare Hawke's Bay, Omahu Marae, Napier, 1994.
Te Komiti Mäori Awhina; Minutes of Meeting - 11 April 1997, Healthcare Hawke's Bay, Napier, 1997.
Te Komiti Mäori Awhina; Minutes of Meeting - 11 September 1996, Healthcare Hawke's Bay, Napier, 1996.
Te Komiti Mäori Awhina; Minutes of Meeting - 14 October 1996, Healthcare Hawke's Bay, Napier, 1996.
Te Komiti Mäori Awhina; Minutes of Meeting - 18 December 1996, Healthcare Hawke's Bay, Napier, 1996.
Te Komiti Mäori Awhina; Minutes of Meeting - 19 August 1997, Healthcare Hawke's Bay, Napier, 1997.
Te Komiti Mäori Awhina; Minutes of Meeting - 19 February 1997, Healthcare Hawke's Bay, Napier, 1997.
Te Komiti Mäori Awhina; Minutes of Meeting - 19 March 1997, Healthcare Hawke's Bay, Napier, 1997.
Te Komiti Mäori Awhina; Minutes of Meeting - 22 July 1997, Healthcare Hawke's Bay, Napier, 1997.
Te Komiti Mäori Awhina; Minutes of Meeting - 23 August 1996, Healthcare Hawke's Bay, Napier, 1996.
Te Komiti Mäori Awhina; Minutes of Meeting - 23 July 1996, Healthcare Hawke's Bay, Napier, 1996.
Te Komiti Mäori Awhina; Minutes of Meeting - 27 June 1997, Healthcare Hawke's Bay, Napier, 1997.
Te Komiti Mäori Awhina; Minutes of Meeting - 27 May 1997, Healthcare Hawke's Bay, Napier, 1997.
Te Komiti Mäori Awhina; Minutes of Meeting - 31 July 1996, Healthcare Hawke's Bay, Napier, 1996.
Te Komiti Mäori Awhina; Minutes of Meeting - 7 August 1996, Healthcare Hawke's Bay, Napier, 1996.

### Commissioned and Externally Prepared Reports

Booz Allen and Hamilton; APPENDIX I - Booz.Allen - Findings and Conclusions - Project Future Deliver Requirements and Quantify Gap, Booz Allen and Hamilton, 1990.
Booz Allen and Hamilton; APPENDIX III - Booz.Allen - Evaluation of Feasibility of Consolidating Acute-Care Hospital Services Hawke's Bay Health Board, Booz Allen and Hamilton, , 1990
Booz Allen and Hamilton; Final Report - Booz.Allen - Evaluation of Feasibility of Consolidating Acute-Care Hospital Services Final Report - Summary, Booz Allen and Hamilton, 1990.
Bridgeport Group, Proposed Hawke's Bay Regional Hospital - Analysis of Submissions, Bridgeport Group, 1994
HMA (Healthcare Management Associates); A Report Responding to the issues Raised by the RHA and the Napier City Council in June, 1994 in Connection with the Development of a Regional Hospital in Hastings., HMA (Healthcare Management Associates), 1994

HMA (Healthcare Management Associates); Quality Measures for the Regional Hospital Development - The Impact of Developing a Regional Hospital - 15 July 1994, HMA (Healthcare Management Associates), 1994
HMA (Healthcare Management Associates); The Proposal to Develop a Regional Hospital for the People of the Hawke's Bay - Validation Exercise Carried Out by Healthcare Management Associates April 1994, HMA (Healthcare Management Associates), 1994
North, Derek; Distance from Acute General Hospital (Hawke's Bay) - (If based in Hastings), 1994
North, Derek; Evaluation From a Clinical Perspective of the Hawke's Bay Regional Hospital Proposals (CONFIDENTIAL), 1995
North, Derek; Evaluation of Clinical Services in Hawke's Bay - February 1994, 1994
Octa Associates Ltd., Healthcare Hawke's Bay A Two Hospital Solution Status Quo Scenario - Final Report - Also Included a Letter to Alister Bowes , Octa Associates Ltd., 1994.
Octa Associates Ltd.; Hastings Hospital Redevelopment - Regional Hospital for Healthcare Hawke's Bay - Includes Letter to Alister Bowes , Octa Associates Ltd., 1994.
Octa Associates Ltd.; Hastings Hospital Redevelopment Final Report For Healthcare Hawke's Bay - Letter to Alister Bowes , Octa Associates Ltd., 1994.
Octa Associates Ltd.; Healthcare Hawke's Bay A Two Hospital Solution Status Quo Scenario - Also Included a Letter to Alister Bowes , Octa Associates Ltd., 1994.
Octa Associates Ltd.; Healthcare Hawke's Bay Regional Hospital Second Site Facilities - Also a Letter Included to Alister Bowes , Octa Associates Ltd., 1994.
Octa Associates Ltd.; Napier Hospital Redevelopment - Regional Hospital For Hawke's Bay - Also Included a Letter to Alister Bowes, Octa Associates Ltd., 1994.
Octa Associates Ltd.; Napier Hospital Redevelopment Final Report - Regional Hospital For Hawke's Bay - Also Included a Letter to Alister Bowes, Octa Associates Ltd., 1994.
Octa Associates Ltd.; Report on Napier City Council Submission - Also Included a Letter to Alister Bowes, Octa Associates Ltd., 1994.
Phoenix Public Relations, Public Relations Programme for Hawke's Bay Area Health Board, 5 November 1990
Research Solutions; The Public's Expectations and Perceptions of Health Care Delivery in Hawke's Bay, Research Solutions, 1993
Treasury; CH/16/10 - File 1 August 1994 - 30 November 1994, Treasury, Wellington, 1994
Treasury; CH/16/10 – Healthcare Hawke's Bay Workplan Status Report, Treasury, Wellington, 1995
Treasury; CH/16/10, Treasury, Wellington, 1993,94
Treasury; CH/16/10/1/95 - Treasury Documents, Treasury, Wellington, 1995
Treasury; CH/16/10/1/96 - Treasury Documents, Treasury, Wellington, 1996
Treasury; File 1 March 98 - 30 September 1998 - Treasury Documents, Treasury, Wellington, 1998

Treasury; Healthcare Hawke's Bay 1996/97 Business Plan Review, Treasury, Wellington, 1996

Internally Prepared Reports

Draft Safety Standards for Mäori Traditional Healing - A Discussion Document - Mihiroa, Hastings Hospital 3 - 5 April 1998, Hastings, 1998.
Flowers, Mark; Napier Services Working Party Minutes of Meetings Public Notices, Healthcare Hawke's Bay, Napier, 1997.
Hawke's Bay Area Health Board, A Guide to the Recommendations For a Single Acute Hospital, 1990.
Hawke's Bay Hospital Board, Strategic Planning Issues 1986-1996, May 1986
Hawke's Bay Area Health Board; Hawke's Bay Area Health Board - Mäori Health Activities and Initiatives 1991 - 1992, Hawke's Bay Area Health Board, Napier, 1992.
Hawke's Bay Hospital Board; Hawke's Bay Health Services - A New Direction, - A Discussion Document, Healthcare Hawke's Bay, Implementation Framework, June 1995.
Healthcare Hawke's Bay; CHE Mäori Health Advisory Committee – an outline of the development and activity of the Committee, Healthcare Hawke's Bay, Napier, 1998.
Healthcare Hawke's Bay; Mäori Health Committee - Business Opportunities and Financial Forecasts, Healthcare Hawke's Bay, Napier, 1997.
Healthcare Hawke's Bay; Mäori Health Committee - Objectives and Action Plan, Healthcare Hawke's Bay, Napier, 1997.
Healthcare Hawke's Bay; Napier Services Working Party Report, Napier, 1997.
Healthcare Hawke's Bay; Board Decision on Hospital Reconfiguration - APPENDIX I, Healthcare Hawke's Bay, Napier, 1994.
Healthcare Hawke's Bay; Board Decision on Hospital Reconfiguration, Healthcare Hawke's Bay, Napier, 1994.
Healthcare Hawke's Bay; Funding Milestone - Report on Central Hawke's Bay, Healthcare Hawke's Bay, Napier, 1995.
Healthcare Hawke's Bay; Health Select Committee - 1996/97 Financial Review of CHE - CHE Questionnaire for the Year 1996/97 - February 1998, Healthcare Hawke's Bay, Napier, 1998
Healthcare Hawke's Bay; Healthcare Hawke's Bay 1994/95 Draft Business Plan Strategic Assessment, Healthcare Hawke's Bay, Napier, 1994.
Healthcare Hawke's Bay; Healthcare Hawke's Bay Board Decision on Hospital Reconfiguration, Healthcare Hawke's Bay, Napier, 1994.
Healthcare Hawke's Bay; Locate Napier's Health Facility in the Central City, Healthcare Hawke's Bay, Napier, 1996.
Healthcare Hawke's Bay; Napier A & E Services, Healthcare Hawke's Bay, Napier, 1997.
Healthcare Hawke's Bay; Public Consultation Meeting on Site of Napier Health Facility, Healthcare Hawke's Bay, Napier, 1997.
Healthcare Hawke's Bay; Public Consultation on a Regional Hospital for Hawke's Bay, Healthcare Hawke's Bay, Napier, 1994.
Healthcare Hawke's Bay; Regional Hospital Briefing Paper, November 1996 - Also Included is a Newspaper Clipping on the Council's Position on the Hospital Issue (4 October 1996), Healthcare Hawke's Bay, Napier, 1996.

Healthcare Hawke's Bay; Regional Hospital Project Implementation Framework, Healthcare Hawke's Bay, Napier, 1995.
Healthcare Hawke's Bay; Regional Hospital Project Newsletter 3, Healthcare Hawke's Bay, Napier, 1995.
Healthcare Hawke's Bay; Response to Social Services Committee Questionnaire - January 1996, Healthcare Hawke's Bay, Napier, 1996.
Healthcare Hawke's Bay; Statement of Intent - 30 June 1995/96 1996/97 1997/98 (Draft?), Healthcare Hawke's Bay, Napier, 1995.
Healthcare Hawke's Bay; Statement of Intent - For the Years 1998/99 1999/00 2000/01, Healthcare Hawke's Bay, Napier, 1998
Healthcare Hawke's Bay; Statement of Intent - July 1993, Healthcare Hawke's Bay, Napier, 1993
Healthcare Hawke's Bay; Statement of Intent for 1996/97 1997/98 1998/99, Healthcare Hawke's Bay, Napier, 1996.
Healthcare Hawke's Bay; Statement of Intent for the years 1995/96 1996/97 and 1997/98, Healthcare Hawke's Bay, Napier, 1995.
Healthcare Hawke's Bay; Statement of Intent for the years 1997/98 1998/99 and 1999/00, Healthcare Hawke's Bay, Napier, 1997.
Healthcare Hawke's Bay; Summary of present position of Healthcare Hawke's Bay, Healthcare Hawke's Bay, Napier, 1997.
Healthcare Hawke's Bay; Te Wahanga Hauora - Strategic Policy and Business Opportunity Presentation to the Board - Mäori Health Services, Healthcare Hawke's Bay, Napier, 1997.
Healthcare Hawke's Bay; The Plan for a Regional Hospital and a Regional Health Service, Healthcare Hawke's Bay, Napier, 1996.
Healthcare Hawke's Bay; Vision Mission Value Goals Strategies - 14 March 1997, Healthcare Hawke's Bay, Napier, 1997.
Healthcare Hawke's Bay; We'd Like to Know What You Think About Our Services - Patient/Client Survey, Healthcare Hawke's Bay, Napier.
Hodges, Wiremu; Foundations for the Mäori Health Policy within Healthcare Hawke's Bay, Healthcare Hawke's Bay, Napier, 1996.
Mäori Health Advisory Committee; Mäori Health Advisory Committee - Role Descriptions/Terms of Reference, Healthcare Hawke's Bay, Napier, 1997.
Mäori Health Committee; Mäori Health Charter - Mäori Health Committee 1991, Hawke's Bay Area Health Board, Napier, 1991.
Regional Hospital Taskforce; Hawke's Bay Regional Hospital Superior Services for the Future, Healthcare Hawke's Bay, Napier, 1994
Stockdale, Monica; Report to the Mäori Health Advisory Komiti - 8 December 1997 - Mäori Addiction Services, Healthcare Hawke's Bay, Napier, 1997.
Wilson, Peter; Consultation on Location of Napier Health Facilities, Healthcare Hawke's Bay, Napier, 1997.

Memoranda

Healthcare Hawke's Bay; Memorandum to Board Members from Healthcare Hawke's Bay, Healthcare Hawke's Bay, Napier, 1994.
Memorandum to Mäori Health Committee - Mäori Health Report - 10 August 1998, Healthcare Hawke's Bay, Napier, 1998
Moore, Kevin; Healthcare Hawke's Bay Memorandum, 3 May 1994
Network Communications Memorandum, 14 April 1994

Network Communications Memorandum, 14 September 1994
Network Communications, Paper 5, Report Release, Wellington, 1994
Network Communications; Memorandum, 14 April 1994

Other:

Braybrooke, Geoff, Continuance of Napier Hospital Bill : Introduction - Unedited Copy Subject to Correction, Napier, 1994
Braybrooke, Geoff, Continuance of Napier Hospital Bill, Napier, 1994
Braybrooke, Geoff, Fax - Questions For Written Answer - Notice Given 22 March 1995 - Reply Due 30 March 1995, Napier, 1995
Braybrooke, Geoff, Fax - Questions For Written Answer - Notice Given 23 November 1995 - Reply Due 5 December 1995, Napier, 1995
Braybrooke, Geoff, Question to Minister of CHE and its Reply, Napier, 1995
Earp, Ria, presentation at Hamilton hui, He Korowai Oranga, July 29 2001
East, Paul; Fax - Questions for Written Answer No 1109 to Michael Laws from Minister of CHEs, 1995
East, Paul; Fax - Questions for Written Answer No 1110 and 1111 to Michael Laws from Minister of CHEs, 1995
East, Paul; Questions For Written Answer - Notice Given 14 June 1995 - Reply Due 22 June 1995, 1995
House of Representatives; Continuance of Napier Hospital Bill – Introduction, House of Representatives, Wellington, 1994.
House of Representatives; Continuance of Napier Hospital Bill – Referral to Health Committee, House of Representatives, Wellington, 1997.
House of Representatives; Journal of H of R - Schedule of Petitions Presented During the Forty Fourth Parliament - continued, House of Representatives, Wellington, 1994.
House of Representatives; Journal of H of R - Schedule of Petitions Presented During the Forty Third Parliament - continued, House of Representatives, Wellington, 1991.
New Zealand Mäori Council v Attorney General, 1987 1 NZLR 641
Order of St John; Order of St John - Central Region Documents, Order of St John, Napier, 1999
Statement of Claim Wai 692, Amendment to Claim 22 July 1999, The Napier Hospital and Health Services Report, Waitangi Tribunal, 2001
Submission of Counsel for urgent hearing, Wai 692, Waitangi Tribunal

## 2. SECONDARY SOURCES.

***Official Publications:***

Central Regional Health Authority, Health Care in Napier, Wellington,1996
Central Regional Health Authority; Towards a Healthier Hawke's Bay, Wellington, 1995

Central Regional Health Authority; Analysis of submissions - Purchasing Intentions for Napier Services to be Provided in Napier, Central Regional Health Authority, Wellington, 1997
Central Regional Health Authority; Central Regional Health Authority Napier Community Meeting - 20 February1996, Central Regional Health Authority, Wellington, 1996
Central Regional Health Authority; Community Health Groups Discussion Document, Central Regional Health Authority, Wellington, 1997
Central Regional Health Authority; Discussion Document Central Regional Health Authority Purchasing Expectations - Healthcare Hawke's Bay Regional Hospital - August 1994, Central Regional Health Authority, Wellington, 1994
Central Regional Health Authority; Discussion Document Central Regional Health Authority Purchasing Expectations - Hawke's Bay Regional Hospital, Central Regional Health Authority, Wellington, 1994.
Central Regional Health Authority; Summary of consultation regarding service provision in Napier, Central Regional Health Authority, Wellington, 1996
Central Regional Health Authority; Towards a Healthier Hawke's Bay, Central Regional Health Authority, Wellington, 1996
Clark, Helen, Minister of Health, New Zealand Health Goals and Targets, Wellington, 1989
Helen Clark, Minister of Health, New Zealand Health Charter, Wellington, 1989
Controller and Auditor General, Third Report for 1998, Chapter 4, Delivering Effective Outputs for Mäori, Wellington, 1998
Creech, Wyatt, Minister of Health, The Government's Medium Term Strategy for Health and Disability Services, Wellington, 1999
Crown Company Monitoring Advisory Unit, Crown Health Enterprises: Briefing to the Incoming Minister, Wellington, 1996.
Crown Company Monitoring Advisory Unit; CCMAU - Crown Company Monitoring Advisory Unit Booklet, Crown Company Monitoring Advisory Unit, Wellington, 1999
Crown Company Monitoring Advisory Unit; CHE Performance Reporting Measures - 1995 - 1996, Crown Company Monitoring Advisory Unit, Wellington, 1995
Crown Company Monitoring Advisory Unit; Guidelines for Interpretation of Monthly Performance - Measure Data, Crown Company Monitoring Advisory Unit, Wellington, 1995
Department of Health & Te Puni Kökiri, Whaia te ora mo te iwi - Strive for the good health of the people, Mäori Health Policy Objectives of Regional Health Authorities and The Public Health Commission, Wellington, 1993.
Department of Health, Whaia te ora mo te iwi - Strive for the good health of the people, Wellington, 1992.
Department of Health; Government's response to Mäori Issues in the Health Sector - Health and Disability Services Bill, Department of Health, Wellington, 1992.
Department of Health; Mäori Health Policy Objectives of Regional Health Authorities and the Public Health Commission, Department of Health, Wellington, 1993.
Department of Health, The Hospital Board Funding Formula, Wellington, 1984

Department of Health; The Treaty of Waitangi and its Implications for the Health Services - Combination of Treaty Documents, Department of Health, Wellington, 1987,88.
Department of Mäori Affairs, Te Urupare Rangapu (The Partnership Response), Wellington 1988
English, Bill and Birch, Bill; Statement of Owners Expectation of CHE - 1997 to 1998, New Zealand Government, Wellington, 1997.
English, Bill and Birch, Bill; Statement of Owners Expectations of CHE, New Zealand Government, Wellington, 1998.
English, Bill and Creech, Wyatt; 1999 Statement of Owners Expectations of Hospital Health Service - Minister of Health, Minister of Finance - March 1999, New Zealand Government, Wellington, 1999.
Gibbs, Alan et al., Unshackling The Hospitals: Report of the Hospital & Related Services Taskforce, Government Printing Office, Wellington, 1988
Hawke's Bay Regional Council, The Mäori Dimension - Overview of Resource Management Significance to Iwi, Hawke's Bay Regional Council, Napier.
Hawke's Bay Area Health Board; Hawke's Bay Area Health Board - Strategic Position Statement and Draft Operating Plan - June 1990, Hawke's Bay Area Health Board, Napier, 1990.
Hawke's Bay Area Health Board; This year a timetable of milestones to July 1998, Hawke's Bay Area Health Board, Napier, 1997.
Health and Disability Services Act 1993
Health and Disability Services Act 1993, as amended in 1995
Healthcare Hawke's Bay; Financial and Operating Report, Healthcare Hawke's Bay, Napier, 1999.
Healthcare Hawke's Bay; Good Health From Best Practice - Annual Review of Healthcare Hawke's Bay Ltd 1995/96, Healthcare Hawke's Bay, Napier, 1996.
Healthcare Hawke's Bay; Hawke's Bay Regional Hospital: Superior Services for the Future, Regional Hospital Task Force March 1994, Healthcare Hawke's Bay, Napier, 1994.
Health Funding Authority, For your information - Public Perceptions of the New Zealand Health System, Health Funding Authority, Wellington, 1998.
Health Funding Authority, National Strategic Plan for Mäori Health 1998-2001, Wellington, 1998
Health Funding Authority, HFA Mäori Health Policy 1998/99, Wellington, 1998
Health Funding Authority, Te Hononga: A newsletter for Mäori Providers, Wellington, September 1998
House of Representatives; 1996/97 Financial Review of Healthcare Hawke's Bay Ltd - Report of the Health Committee, House of Representatives, Wellington, 1998.
King, Annette, Minister of Health, He Korowai Oranga, Mäori Health Strategy Discussion Document, April 2001
King, Annette, Minister of Health, Mäori Health Cabinet Papers, Overview and Treaty of Waitangi (2000, http://www.executive.govt.nz/minister/king/cabinet00-08/index.html)
King Annette, Minister of Health, Health Moves, Issue 16, August 2000
King, Annette, Minister of Health, He Korowai Oranga, Mäori Health Strategy Discussion Document, Wellington, April 2001

King, Annette, Minister of Health, The Primary Health Care Strategy, Wellington, February 2001
Lawson Te Aho, Keri, Kia Piki Te Ora O Te Taitamariki, The New Zealand Youth Suicide Prevention Strategy, Te Puni Kökiri, 1998
Malcolm, Laurence, Lyn Wright, and Pauline Barnett, The Development of Primary Care Organisations in New Zealand, Treasury/Ministry of Health, Wellington, 1999
Mäori Health Commission, Report to The Minister of Mäori Affairs, 10 February 1998.
McGuigan T., A Health Service For New Zealand, Government Printer, Wellington, 1975
McKinlay, P., 'The Role of the State', Paper prepared for the Royal Commission on Social Policy, Wellington, Royal Commission of Social Policy, 1987
Mental Health Commission; Blueprint for Mental Health Services in New Zealand - How Things Need to Be - Mental Health Commission December 1998, Mental Health Commission, Wellington, 1998.
Midland Regional Health Authority Family Health Unit, A Health Professional's Guide to Capitation, Hamilton, 1995
Ministerial Planning Group, Ka Awatea: Report of the Ministerial Planning Group, Office of the Minister of Mäori Affairs, Wellington, 1991
Ministry of Health, Action for Health and Independence: Bridging the Gap between Actions and Outcomes: The Population Perspective – Mäori Health Issues, Wellington, 1998
Ministry of Health, Kia Whai te Maramatanga: The Effectiveness of Health Messages For Mäori, 1994.
Ministry of Health, Looking Forward, Wellington, 1994
Ministry of Health, Mäori Health Directorate, Information Sheet - Provisions for Mäori Health and the Treaty of Waitangi in the New Zealand Public Health and Disability Act 2000 15 March 2001 update.
Ministry of Health, Mäori Health Directorate, Information Sheet - Provisions for Mäori Health and the Treaty of Waitangi in the New Zealand Public Health and Disability Act 2000 19 September 2000 update.
Ministry of Health, Your Guide to the Crown's Objectives for Regional Health Authorities, Ministry of Health, Wellington, 1993
Ministry of Social Policy, Post Election Briefing, 1999.
Ministry of Youth Affairs, Annual Report, 1999.
National Advisory Committee on Core Health Services, The Core Debate Issue #1, Wellington, 1994:1
National Health Committee - The Social and Economic Determinants of Health in New Zealand: Action to Improve Health, Wellington, 1998.
National Interim Provider Board, Providing Better Health Care for New Zealanders, Wellington, May 1992.
Nelson Health Services Advisory Committee, The Report of the Nelson Health Services Advisory Committee, Nelson Area Health Board, July 1985
New Zealand Government, National-New Zealand First Coalition Agreement, Wellington, 1996
New Zealand Public Health and Disability Act 2000
New Zealand Public Health and Disability Bill 48-1 (2 August 2000)
Palmer, Geoffrey, Directions for State Enterprise, Government Printer, Wellington, 1986

Parata, Hekia & Mason Durie, Department of Health - Mäori Health Review, Wellington, 1993
Prebble, Mark, Chief Executive, Department of the Prime Minister and Cabinet, Key Government Goals, Letter to State Sector Chief Executives, 11 April 2001
Public Health Commission, He Matariki: A Strategic Plan for Mäori Public Health, 1995.
Public Health Commission, Hui Taumata, Wellington, 1994.
Race Relations Conciliator, New Zealand Public Health & Disability Bill, Submission to the Health Select Committee, 2000
Resource Management Act 1991
Royal Commission on Social Policy, Report of the Royal Commission on Social Policy, Vol. 2, Wellington, 1988.
Royal Commission on Social Policy, Terms of Reference Discussion Booklet, Wellington, 1987
Royal Commission on Social Policy, The Treaty Of Waitangi and Social Policy, Wellington, 1987
Scott C, G Fougere & J Marwick, Choices For Health Care, Report of the Health Benefits Review, Government Printer, Wellington, 1986
Shipley, Jenny; Health Services 1996 - Jenny Shipley, New Zealand Government, Wellington, 1995
Shipley, Jenny; Mäori Policy Guidelines - A Summary - Honourable Jenny Shipley, New Zealand Government, Wellington, 1995.
Shipley, Jenny; Policy Guidelines for Mäori Health, 1995/96, Wellington, 1995.
Shipley, Jenny; Policy Guidelines for Regional Health Authorities 1996/97, New Zealand Government, Wellington, 1996.
State Services Committee; Administration of Statutory Bodies and Other Committees, State Services Committee, Wellington, 1997.
Steering Group to oversee Health and Disability Changes to the Minister of Health and the Associate Minister of Health, Implementing the Coalition Agreement on Health, 1997
Stent, Robyn; Health and Disability Commissioner, Canterbury Health Ltd., Wellington, 1998
Te Puni Kökiri, A Guide For Departments on Consultation with Iwi, Te Puni Kökiri, Wellington, 1993
Te Puni Kökiri; E Mua Kai Kai, The Experience of the Raukura Hauora O Tainui Rust, Te Puni Kökiri, Wellington, 1993.
Te Puni Kökiri, Health and Disability Sector Changes and Their Implementation, 21 January 2000 (advice to the Minister of Mäori Affairs released under the Official Information Act, and released in a press release by the Hon Wyatt Creech 29 January 2000)
Te Puni Kökiri, Mana Tangata: Draft Declaration on the Rights of Indigenous Peoples 1993 -background and discussion on key issues 1994.
Te Puni Kökiri, Post Election Briefing, Wellington, 1999.
Te Puni Kökiri, Review of the Ministry of Health Service Delivery to Mäori, Wellington, 1997.
Te Puni Kökiri, Te Ara Ahu Whakamua – Hui Report, 1994.
The Ministerial Advisory Committee on A Mäori Perspective, Puao-te-ata-tu, Department of Social Welfare, Wellington, 1986.
The New Zealand Treasury, Post Election Briefing, Wellington, 1987

Turia, Tariana, Associate Minister of Mäori Affairs Press Release, Lecture Notes, Closing The Gaps & Capacity Building, 7 July 2000
Upton, Simon, Why we must reform our health system, Health Reform Newsletter, 1-8,1990.
Upton, Simon; Your Health and the Public Health, Government Printer, Wellington, 1991.
Waitangi Tribunal, Wai-4, Kaituna River Report Government Printer, Wellington, 1984
Waitangi Tribunal, Wai-692, The Napier Hospital and Health Services Report, Legislation Direct, Wellington, 2001
Waitangi Tribunal, Wai-6, Report of the Waitangi Tribunal on the Motunui-Waitara Claim, Government Printer, Wellington, 1983

***Newspapers:***

Daily Telegraph, 20 December 1990
Daily Telegraph, 20 December 1994
Daily Telegraph, 25 January 1995
Daily Telegraph, 8 May 1995
Daily Telegraph, 7 July 1995
Daily Telegraph, 27 July 1995
Daily Telegraph, 24 January 1998
Daily Telegraph, 18 April 1998
Hawke's Bay Herald Tribune, 6 April 1995
Sunday Star Times, May 28 2000
The Dominion, May 23, 1998.

***Other Media:***

Bolger, Jim; Newztel Log 1ZB, Paul Holmes and Jim Bolger - 15 August 1994, 1ZB (Newztel), Auckland, 1994.
Hill, Kim, Newztel Log, Radio New Zealand, 30 August 2000
King, Annette, Minister of Health Radio New Zealand "Checkpoint" 5-6 PM Friday 25 February 2000
New Zealand Labour Party, Labour On Mäori Development - He Putahitanga Hou, Part 1, http://www.labour.org.nz/Frame-Policy.html, Wellington, 1999
Ramsden, Eric, The Sun, September 1927.
Wilson, Peter; Newztel News - RNZ "Morning Report" - Presenter (Mike Hosking) - Peter Wilson (Chairman of Hawke's Bay CHE), Healthcare Hawke's Bay, Napier, 1995.

***Press Releases:***

English, Bill; Media Release - Minister of Health: Hospital Plan Delivery Certainty and Security and Speech to Launch Hospital Services Plan at Wanganui, New Zealand Government, Wellington, 1998.
Healthcare Hawke's Bay; Media Release, 3 November 1997.
Healthcare Hawke's Bay; 3 Press Releases - Regional Hospital in Hastings to Proceed, Healthcare Hawke's Bay Meets Requirements of the Court Regional

Hospital Services Remain Unchanged, Healthcare Hawke's Bay, Napier, 1995.
Healthcare Hawke's Bay; Media release Healthcare Hawke's Bay: Healthcare Hawke's Bay Receives Government Agreement for Regional Hospital, Healthcare Hawke's Bay, Napier, 1995.
Healthcare Hawke's Bay; Media Release, April 1994
Kirton, Neil; Media Release from Neil Kirton - Calan Group View on Napier's New Medical Centre in Disneyland says Kirton, Napier, 1999.
Scott, Duncan; Press Statement By Dr Duncan Scott Chairman - Regional Group on the Hawke's Bay Regional Hospital, Regional Group on the Hawke's Bay Regional Hospital, 1994
Shipley, Jenny and East, Paul, Media Release from Ministers of CHEs and Health, New Zealand Government, Wellington, 1994.
Shipley, Jenny and East, Paul; Media Release from Ministers of CHEs and Health, New Zealand Government, Wellington, 1994.
Turia, Tariana, Associate Minister of Health, Press Release: New Zealand Government 10 March 2000.

***Other:***

Alves, Dora, The Mäori and the Crown: An Indigenous People's Struggle for Self-Determination, Greenwood Press, Westport, Connecticut, 1999.
Ashton, Toni, From Evolution to Revolution - Restructuring the New Zealand Health System, in Seedhouse, David (ed), Reforming Health Care: the philosophy and practice of International Health Reform, John Wiley & Sons, Chichester, 1995.
Ave K. and B. MacLean,' Waahi Health Programme ; An Evaluation', unpublished paper for the Community Psychology Department, University of Waikato, 1991.
Blank, Robert, Agenda Setting and Policy Context, in Davis Peter, & Toni Ashton (eds), Health and Public Policy in New Zealand, Oxford University Press, Auckland, 2000
Blank, Robert, New Zealand Health Policy: A Comparative Study, Oxford University Press, Auckland, 1994
Bloom, Abby, Health Reform in Australia and New Zealand, Oxford University Press, Melbourne, 2000
Boston, Jonathan, et al, Public Management: The New Zealand Model, Oxford University Press, Auckland, 1996
Brannigan, Michael, Oregon's Experiment, Chapter 2 in Seedhouse, David (ed), Reforming Health Care: the philosophy and practice of International Health Reform, John Wiley & Sons, Chichester, 1995.
Braybrooke, Geoff; Napier Electorate Referendum 1995 – Have Your Say and Make It Count, Napier, 1995.
Britton, Steve, Richard LeHeron, and Eric Pawson (eds), Changing Places in New Zealand: A Geography of Restructuring, New Zealand Geographical Society, Christchurch, 1992.
Brook Cowen, Penelope, Neo-Liberalism Chapter 6.3 in Miller, Raymond, (ed) New Zealand Politics in Transition, Oxford University Press, Auckland, 1997

Brunton, Warwick; The place of history in health policy making: a view from the inside, Linda Bryder and Derek Dow (Eds.) New Countries and Old Medicine, Pyramid press, Auckland, 1994
Chew, S.K., The Process of Privatisation in New Zealand: Implications For Ministerial Responsibility and the Continuing Role of the Government with respect to State Owned Enterprises, Victoria University, Wellington, April 1989
City Medical; City Medical News, City Medical, Napier, 1997
Clark, M, and E Sinclair (eds), Purpose, Performance, & Profit: Redefining the Public Sector, Studies in Public Administration, No #2, NZ Institute of Public Administration, Wellington, 1986.
Cunningham, Chris, & Mason Durie, Te rerenga hauora, Chapter 14 in Davis, Peter & Kevin Dew (eds), Health and Society in Aotearoa New Zealand, Oxford University Press, Auckland, 1999
Cunningham, Chris and Cindy Kiro, Rapuhia mo te Hauora Mäori, Chapter 3 in Davis, Peter, & Toni Ashton (eds), Health and Public Policy in New Zealand, Oxford University Press, Auckland, 2000
Danzon, P and S Begg, Options For Healthcare in New Zealand, Report For the Business Roundtable, CS First Boston NZ Ltd, Wellington, 1991.
Davis, Peter, & Toni Ashton (eds), Health and Public Policy in New Zealand, Oxford University Press, Auckland, 2000
Davis, Peter & Kevin Dew (eds), Health and Society in Aotearoa New Zealand, Oxford University Press, Auckland, 1999
Dawson, Richard, The Treaty of Waitangi and the Control of Language, Institute of policy Studies, Victoria University, Wellington, 2001
Dougherty, Charles, Bad Faith and Victim Blaming, Chapter 17 in Seedhouse, David (ed), Reforming Health Care: the philosophy and practice of International Health Reform, John Wiley & Sons, Chichester, 1995.
Douglas, Roger, There's Got to be a Better Way, Fourth Estate Books, Wellington, 1980
Douglas, Roger, Unfinished Business, Random House Auckland, 1993
Douglas, Roger, and L Callen, Towards Prosperity: People and Politics in the 1980s – A Personal View, David Bateman, Auckland, 1987
Dow, Derek, Mäori Health and Government Policy 1840-1940, Victoria University Press, Wellington, 1999
Durie, Mason; Mental Health and Mäori Development, Australian and New Zealand Journal of Psychiatry 1999; 33: 5-12
Durie, Mason; The Treaty of Waitangi and health care, New Zealand Medical Journal, 1989: 102: 283-5
Durie, Mason; Whaiora - Mäori Health Development, Oxford University Press, Auckland, 1994
Durie, Mason; Whaiora - Mäori Health Development (2nd Ed), Oxford University Press, Auckland, 1998
Easton, Brian, The Commercialisation of New Zealand, Auckland University Press, Auckland, 1997
Ellis, Judge; In the High Court of New Zealand Napier Registry CP29/94, High Court, Napier, 1994.
Ferguson, Lisa; Scoping Report - Waitangi Tribunal - The Napier Services Claim, Harrison Ferguson Associates, Hamilton, 1998.

Finlayson, Mary, Policy Implementation and Modification, Chapter 8 in Davis Peter, & Toni Ashton (eds), Health and Public Policy in New Zealand, Oxford University Press, Auckland, 2000
Gladstone, David & Michael Goldsmith, Health Care Reform in the UK, Chapter 4 in Seedhouse, David (ed), Reforming Health Care: the philosophy and practice of International Health Reform, John Wiley & Sons, Chichester, 1995.
Gwynn, Robin; Denial of Democracy, Cosmos Publications, Napier, 1998
Hawke, G, Government in the New Zealand Economy, Planning Paper No 13, New Zealand Planning Council, Wellington, 1982.
Hayward, Bronwyn, Public Participation Chapter 8.2 in Miller, Raymond, (ed) New Zealand Politics in Transition, Oxford University Press, Auckland, 1997
Heaney, Mark; Statement from Mark Heaney Development and Planning Manager for Healthcare Hawke's Bay, Healthcare Hawke's Bay, Napier, 1998.
International Medical Statistics (IMS) Ltd; Public Image Monitor - Healthcare Hawke's Bay Quarter 1 1994, International Medical Statistics (IMS) Ltd, 1994.
Jesson, Bruce, Only their Purpose is Mad: The Money men take Over New Zealand, Dunmore Press, Palmerston North, 1999.
Johnston, J., and A von Tunzelmann, The State in Business, Public Enterprises in New Zealand, Planning Paper No 15, New Zealand Planning Council, Wellington, 1982.
Kai Tiaki Nursing New Zealand; New Care Threatens Patient Safety, New Zealand Nurses Association, Wellington, 1997.
Kawharu, Hugh, (ed), Mäori and Pakeha Perspectives of the Treaty of Waitangi, Oxford University press, Auckland, 1989
Kelsey, Jane, A Question of Honour? Labour and the Treaty 1984-1989, Allen and Unwin/ Port Nicholson Press, Wellington, 1990
Kirton, Neil; Neil Kirton MP - The Hospital Issue: Review of Napier Health Services, Napier, 1997.
Lange, Raeburn, 'The revival of a dying race: a study of Mäori health reform 1900-1918 and its nineteenth century background', MA Thesis University of Auckland, 1972
Lifton, Robert Jay, The Nazi Doctors: Medical Killing and the Psychology of Genocide, Basic Books A subsidiary of Perseus Books, L.L.C, 1986.
Lummis, Trevor, Listening to History: The authenticity of oral evidence, Hutchinson, London, 1987.
Maraenui Family Centre; Maraenui - A Community Health Survey, Maraenui Family Centre, Napier, 1989.
Meijl, Toon Van, Te Whare Rapuora O Waahi Pa Marae, An Overview of A Mäori Community Health Programme, CMSR, University of Waikato, 1987
Mendlesohn, R., Social Security in the British Commonwealth, London, Athlone Press, 1954
Miller, Raymond, (ed) New Zealand Politics in Transition, Oxford University Press, Auckland, 1997
Moore, J., Secretary of State for Health Conservative Party Conference, London, October 1987.
Napier City Council; Hospital Submission - March 1991, Napier City Council, Napier, 1991.

Napier City Council; Volume II Appendices to the Napier City Council - Hospital Submission, Napier City Council, Napier, 1991.
Napier Parent's Centre; Maternity Services Survey - 1997 Also Included are Three Letters Concerning the Survey and a Newspaper Article on Maternity Care at Napier, Napier Parent's Centre, Napier, 1997,98
Napier Pilot City Trust; Hospital Submissions, Napier Pilot City Trust, Napier, 1994.
Napier Services Working Party; Membership - Napier Services Working Party, Healthcare Hawke's Bay, Napier, 1997,98
New Zealand Doctor; Napier GPs Keen to Run New Emergency Services, New Zealand Doctor, 1997
New Zealand Law Society; NZLS Seminar - April 1989 - The Treaty of Waitangi, New Zealand Law Society, 1994.
New Zealand Planning Council, New Zealand at the Turning Point, New Zealand Planning Council, Wellington, 1976
Nicolson, M., 'Medicine and Racial Politics: Changing images of the New Zealand Mäori in the Nineteenth Century', in D. Arnold (ed), Imperial Medicine and Indigenous Societies, Manchester, 1988.
Orange, Claudia, The Treaty of Waitangi, Allen and Unwin/ Port Nicholson Press, Wellington, 1987
Palmer, Geoffrey, New Zealand's Constitution in Crisis: reforming Our Political System, Oxford University Press, Auckland 1992
Parata, Hekia, Mainstreaming: A Mäori Affairs Policy Social Policy Journal of New Zealand 3: 40-51, 1994
Parsons, Pat, Downgrading of Napier Hospital, Napier, 1998.
Parsons, Pat, Tribunal Report - The Treaty of Ahuriri Supplementary Evidence of Vincent O'Malley in relation to the Ahuriri Purchase of 1851, Waitangi Tribunal, Wellington, 1997.
Pierson, Christopher, Beyond the Welfare State? Polity Press, Cambridge, 1991.
Pomare, Eru, et al; Hauora: Mäori Standards of Health III, A Study of the Years 1970 – 1991, North Health and the Health Research Council of New Zealand, Auckland, 1995.
Prucha, Francis Paul (ed), Documents of United States Indian Policy (2nd ed), University of Nebraska Press, Lincoln, 1990
Reid, Paparangi, Nga mahi whakahaehae a te tangata tiriti, Chapter 5 in Davis, Peter & Kevin Dew (eds), Health and Society in Aotearoa New Zealand, Oxford University Press, Auckland, 1999
Reid, Paparangi; Perspectives on Medical Training, Chapter in Advisory Committee on the Medical Workforce, Cultural Considerations in Health, 1989.
Richards, Ray, Two Social Security Acts, Chapter 1 in Closing the Door to Destitution, the Shaping of the Social Security Acts of the United States and New Zealand, University Park, PA, Pennsylvania University Press, 1994.
Rudd, Chris,, The Welfare State, Chapter 5.2 in Miller, Raymond, (ed) New Zealand Politics in Transition, Oxford University Press, Auckland, 1997.
Said, Edward, Orientalism, Penguin Books, London, 1978.
Salmond, George; Hawke's Bay Regional Hospital - Submission to Healthcare Hawke's Bay Ltd from George Salmond Director, Health Services Research Centre - Victoria University of Wellington, Wellington, 1995

Scott, Graham; Government Reform in New Zealand, Occasional Paper 140, International Monetary Fund, 1996.
Seedhouse, David (ed), Reforming Health Care: the philosophy and practice of International Health Reform, John Wiley & Sons, Chichester, 1995.
Shaikh, Jill Margaret; The influence of local government politics on the strategic planning of a health authority: a case study of acute-care health services in Hawke's Bay, (Thesis), Massey University, 1992.
Shear-Wood, Corrine, 'Blood Pressure and Related Factors Among the Mäori and Pakeha Communities of Huntly', CMSR, University of Waikato, 1982
Tainui Mäori Trust Board, Tainui Health Plan, 1990
United Nations, Declaration on the Right to Development, 1986
United Nations, Draft Declaration on the Rights of Indigenous Peoples, 1990
Walker, Ranginui, Ka Whawhai Tonu Matou: Struggle Without End, Penguin Books, Auckland, 1990
Ward, Alan, An Unsettled History: Treaty Claims in New Zealand Today, Bridget Williams Books, Wellington, 1999
World Health Organisation, Alma Ata Declaration, 1978